S I P E ACCIDENT INVESTIGATION REPORT

The injured employee's supervisor shall complete this Accident Investigation Report immediately following an illness or injury. All questions must be answered completely. **PLEASE PRINT OR TYPE.**

A. GENERAL DATA

1. SCHOOL DISTRICT	2. SCHOOL SITE	3. SITE PHONE
4. EMPLOYEE NAME	5. SOCIAL SECURITY NUMBER	6. DATE OF BIRTH (MM/DD/YY)
7. HOME ADDRESS (NUMBER & STREET, CITY, ZIP)	8. PHONE NUMBER	9. SEX ☐ MALE ☐ FEMALE
10. OCCUPATION (REGULAR JOB TITLE) / 11. DATE OF HIRE	12. DATE EMPLOYER WAS NOTIFIED OF THE INCIDENT	13. DATE THE EMPLOYEE WAS PROVIDED WITH CLAIM FORM DWC-1
14. EMPLOYEE USUALLY WORKS _____HRS/DAY _____DAY/WEEK _____ TOTAL WEEKLY HOURS	15. EMPLOYMENT STATUS (CHECK APPLICABLE STATUS AT TIME OF INJURY) ☐ FULLTIME ☐ PART TIME ☐ TEMPORARY ☐ SEASONAL	
16. DATE OF INCIDENT	17. TIME OF INCIDENT _____:_____ AM _____:_____ PM	18. TIME EMPLOYEE BEGAN WORK _____:_____ AM _____:_____ PM / 19. IF EMPLOYEE DIED, DATE OF DEATH
20. UNABLE TO WORK AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO	21. LAST DAY WORKED / 22. DATE RETURNED TO WORK	23. IF STILL OFF WORK, CHECK THIS BOX ☐ EXPECTED RETURN DATE:
24. NAME AND ADDRESS OF PHYSICIAN (NUMBER AND STREET, CITY, ZIP)		25. PHYSICIAN PHONE NUMBER
26. IF THE PHYSICIAN IS NOT A DISTRICT-APPROVED PANEL DOCTOR, DOES THE EMPLOYEE HAVE A FORM ON FILE TO SEE A PERSONAL PHYSICIAN OR CHIROPRACTOR? ☐ YES ☐ NO		
27. WHO TRANSPORTED THE EMPLOYEE TO THE DOCTOR?		

B. INJURY/ILLNESS DATA

1. CLASS OF INJURY

☐ FATALITY ☐ LOST WORKDAY ☐ RESTRICTED WORK ☐ MEDICAL ONLY ☐ FIRST AID ☐ OTHER

2. NATURE OF INJURY

☐ AMPUTATION ☐ ASPHYXIATION ☐ BURN, SCALD ☐ BURN, CHEMICAL ☐ CONCUSSION
☐ CONTUSION/BRUISE ☐ CUT, LACERATION ☐ DERMATITIS ☐ DISLOCATION ☐ ELECTRIC SHOCK
☐ FLASHBURN ☐ FOREIGN BODY IN EYE ☐ FRACTURE ☐ FREEZING, FROSTBITE ☐ RADIATION EFFECTS
☐ HEAT/SUNSTROKE ☐ HERNIA, RUPTURE ☐ POISONING, SYSTEMIC ☐ PNEUMOCONIOSIS ☐ HEARING LOSS
☐ STRAIN/ SPRAIN ☐ OCCUPATIONAL DISEASE ☐ INFECTIOUS DISEASE ☐ SCRATCHES, ABRASIONS ☐ OTHER: _____

3. PART OF BODY AFFECTED ☐ RIGHT SIDE ☐ LEFT SIDE

☐ HEAD ☐ EYE ☐ BACK/NECK
☐ SHOULDER ☐ ARM ☐ ELBOW
☐ CHEST ☐ ABDOMEN ☐ HIP
☐ LEG ☐ KNEE ☐ FOOT
☐ TOE ☐ HAND ☐ THUMB
☐ INDEX FINGER ☐ MIDDLE FINGER ☐ RING FINGER
☐ LITTLE FINGER ☐ OTHER: _____

4. ACCIDENT TYPE

☐ STRUCK BY ☐ STRUCK AGAINST ☐ FALL TO FOOT LEVEL
☐ MOTOR VEH. ACCIDENT ☐ PUBLIC TRANSPORT. ☐ RUBBED OR ABRADED
☐ OVEREXERTION ☐ CONTACT W/ ELECTRIC ☐ BODILY REACTION
☐ CONTACT W/ CHEMICAL ☐ CONTACT W/ TEMPERATURE ☐ EXPOSURE/ PHYSICAL HAZARDS
☐ INHALATION OF TOXIC SUBSTANCE ☐ FALL FROM ELEVATION
☐ CAUGHT IN, UNDER, INBETWEEN ☐ OTHER: _____

5. SOURCE OF INJURY

☐ AIR PRESSURE ☐ ANIMALS, INSECTS ☐ ANIMAL PRODUCTS ☐ CONVEYORS ☐ TEXTILE ITEMS ☐ VEHS., POWERED ☐ STRUCTURES ☐ WORKING SURFACE
☐ COLD/HEAT ☐ CLOTHING, SHOES ☐ COAL/PETROL PRODUCTS ☐ GLASS ITEMS ☐ HAND TOOLS ☐ PARTICULATE ☐ DRUGS, MEDICINES ☐ ELECTRICAL APPARATUS
☐ CERAMIC ITEMS ☐ CHEMICALS ☐ FLOORS, LEVEL SURFACES ☐ FURNITURE, FIXTURES ☐ METAL ☐ NOISE, VIBRATION ☐ TOOLING, FIXTURES ☐ HOISTING APPARATUS
☐ RADIATING SUBSTANCES ☐ EXCAVATIONS, TRENCHES ☐ CONTAINERS, PACKAGES ☐ MACHINES ☐ MECHANICAL POWER ☐ SCRAP, WASTES, DEBRIS ☐ STEAM ☐ DOLLIES, HAND TRUCKS
☐ PUMPS, PRIME MOVERS ☐ PAPER, PLASTIC, FOIL ☐ LADDERS, SCAFFOLDS ☐ CLEANING COMPOUNDS ☐ FIRE, FLAME, SMOKE ☐ BODILY MOTION ☐ BOILERS, PRESSURE VESSELS ☐ PLANTS, TREES, VEGETATION
☐ WOOD ITEMS (PULP, LUMBER) ☐ INFECTIOUS, PARASITIC AGENTS ☐ WORK AREA ENVIRONMENT ☐ OTHER: _____

6. UNSAFE ACT

☐ HORSEPLAY ☐ FAILURE TO SECURE, WARN, OR LOCKOUT ☐ OPERATING OR WORKING AT AN UNSAFE SPEED
☐ IMPROPER LIFTING OR CARRYING ☐ WORKING ON ENERGIZED, PRESSURIZED EQUIP. ☐ MISUSE OF EQUIPMENT, TOOLS, MATERIALS, VEHICLE
☐ DRIVER/OPERATOR ERROR ☐ FAILURE TO USE EQUIPMENT REQUIRED OR PROVIDED ☐ FAILURE TO FOLLOW INSTRUCTIONS ☐ FAILURE TO USE PROPER PERSONAL PROTECTIVE EQUIP.
☐ IMPROPER USE OF HANDS OR BODY PARTS ☐ UNSAFE PLACING, MIXING, LOADING ☐ OPERATING OR ACTING W/O AUTHORIZATION
☐ TAKING AN USAFE BODILY POSITION OR POSTURE ☐ INATTENTION TO FOOTINGS OR SURROUNDINGS ☐ USING UNSAFE EQUIPMENT ☐ REMOVING OR MAKING SAFETY DEVICES INOPERATIVE
☐ FAILURE TO WEAR SAFE PERSONAL ATTIRE ☐ OTHER: _____ ☐ NO UNSAFE ACT

7. UNSAFE CONDITION

☐ POOR HOUSEKEEPING ☐ GUARDING NOT PROVIDED ☐ INADEQUATE TRAFFIC CONTROL
☐ INADEQUATE ILLUMINATION ☐ INADEQUATE OR IMPROPERLY DESIGNED VENTILATION ☐ INADEQUATE OR IMPROPER GUARDING
☐ NATURAL HAZARDS (TERRAIN, ELEMENTS, ETC.) ☐ HAZARDOUS CONDITIONS ☐ IMPROPER STACKING, AND/OR PALLETIZING
☐ UNAVAILABILITY OF REQUIRED ELEMENTS ☐ UNSUITED DESIGN, LAYOUT CONSTRUCTION OR PRE-SCRIBED WORK METHODS
☐ DEFECTS OF EQUIPMENT, TOOLS, MATERIALS, VEHICLES ☐ NO HAZARDOUS CONDITION
☐ OTHER: _____

8. SUPERVISORY RESPONSIBILITY

☐ FAILURE TO ENFORCE SAFETY RULES ☐ INADEQUATE INSPECTION OF EQUIPMENT OR WORK
☐ FAILURE TO FOLLOW INSTRUCTIONS ☐ INCORRECT JOB ASSIGNMENT
☐ INADEQUATE TRAINING/ INSTRUCTION PROVIDED ☐ INEFFECTIVE IMMEDIATE SUPERVISION
☐ FAILURE TO PROVIDE SAFE OR CORRECT TOOLS ☐ FAILURE TO PROVIDE PERSONAL PROTECTIVE EQUIPMENT
☐ NONE
☐ OTHER: _____

C. DESCRIPTION OF ACCIDENT (IF ADDITIONAL SPACE IS NEEDED, ATTACH A PLAIN SHEET)

1. STATEMENT FROM INJURED EMPLOYEE

2. NAMES AND STATEMENTS FROM WITNESSES

3. SPECIFIC LOCATION OF ACCIDENT

4. DESCRIBE HOW THE INJURY HAPPENED OR THE EVENTS LEADING TO THE ILLNESS (INCLUDE JOB TASK OR ACTIVITY)

5. WHY DID THE ACCIDENT OCCUR? (DESCRIBE ANY UNSAFE ACTS OR CONDITIONS)

D. CORRECTIVE ACTION

1. WHAT CORRECTIVE ACTION IS BEING TAKEN TO PREVENT REOCCURRENCE?

2. WHO IS RESPONSIBLE FOR CORRECTIVE ACTION AND WHEN IS THE EXPECTED COMPLETION DATE?

E. REQUIRED SIGNATURES

INVESTIGATED BY	DATE:
REVIEWED BY DIRECTOR/ADMINISTRATOR	DATE:
REVIEWED BY DISTRICT SAFETY COORDINATOR	DATE: