Key Risk
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CENTER FOR SOCIAL CHANGE
Accident Investigation Report
Employee Statement

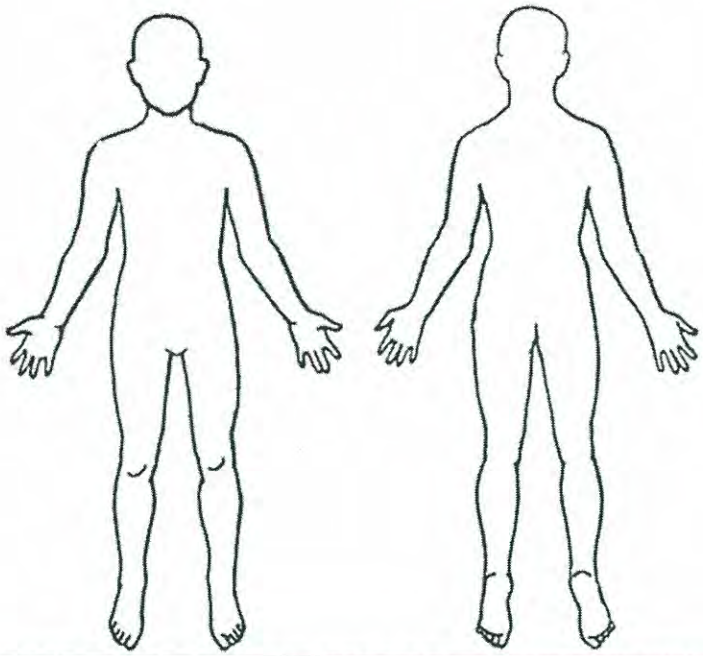
Essentials Risk Management

Everyone needs to work together and make every effort to minimize on-the-job injuries. If an injury does occur, it is important that Supervisors follow appropriate procedures to get timely medical care and conduct a thorough investigation. This employee statement provides assistance in finding the facts surrounding the accident to prevent future similar accidents in consideration of all contributing factors. This form is intended for internal use and not to be used to report claims.

Approx. Date/Time of Event:		**Name of Employee Providing This Statement:**	
Date/Time of Statement:	**Location/Worksite:**	**Are you primary employee involved:** ☐ YES ☐NO, I am a Witness	**Telephone Number:**

Please be as detailed as possible and take whatever time is necessary to thoroughly contribute to this incident review. Use additional pages as needed. You will be assisted with any writing difficulties as needed. Thank you for your assistance.

INDICATE where any injuries occurred on the pictures below:



WHEN precisely did these events occur? (During break, during an installation or delivery, during overtime etc.)

WHO all was involved? (Any injured parties, other witnesses, a vendor or contractor, or anyone that can provide important information?)

WHERE exactly did the events occur? Please be as specific as possible regarding location

WHAT happened? Explain in detail all you know about the accident

HOW did the event occur?

WHY in your opinion did the event occur?

RECOMMENDATIONS: HOW in your opinion could the incident have been prevented and WHAT is needed to be done to prevent future incidents?

RECOMMEND

My signature below acknowledges that I have been completely truthful with all I know about this incident at this time. I will immediately forward additional information to management as it may further appear to me.

Signature of Employee : _____ Date: _____

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CENTER FOR SOCIAL CHANGE
Accident Investigation Report
Witness Statement

Essentials
Risk Management

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Approx. Date/Time of Event:		**Name of Employee Providing This Statement:**	
Date/Time of Statement:	**Location/Worksite:**	**Are you primary employee involved:** ☐ **YES** ☐ **NO, I am a Witness**	**Telephone Number:**

Please be as detailed as possible and take whatever time is necessary to thoroughly contribute to this incident review. Use additional pages as needed. You will be assisted with any writing difficulties as needed. Thank you for your assistance.

WHEN precisely did these events occur? (During break, during an installation or delivery, during overtime etc.)

WHO all was involved? (Any injured parties, other witnesses, a vendor or contractor, or anyone that can provide important information?)

WHERE exactly did the events occur? Please be as specific as possible regarding location

WHAT happened? Explain in detail all you know about the accident

HOW did the event occur?

WHY in your opinion did the event occur?

RECOMMENDATIONS: HOW in your opinion could the incident have been prevented and WHAT is needed to be done to prevent future incidents?

RECOMMEND

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Signature of Employee : _____ Date: _____

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CENTER FOR SOCIAL CHANGE
Accident Investigation Report
Witness Statement

Essentials Risk Management

Everyone needs to work together and make every effort to minimize on-the-job injuries. If an injury does occur, it is important that Supervisors follow appropriate procedures to get timely medical care and conduct a thorough investigation. This employee statement provides assistance in finding the facts surrounding the accident to prevent future similar accidents in consideration of all contributing factors. This form is intended for internal use and not to be used to report claims.

Approx. Date/Time of Event:		**Name of Employee Providing This Statement:**	
Date/Time of Statement:	**Location/Worksite:**	**Are you primary employee involved:** ☐ **YES** ☐ **NO, I am a Witness**	**Telephone Number:**

Please be as detailed as possible and take whatever time is necessary to thoroughly contribute to this incident review. Use additional pages as needed. You will be assisted with any writing difficulties as needed. Thank you for your assistance.

WHEN precisely did these events occur? (During break, during an installation or delivery, during overtime etc.)

WHO all was involved? (Any injured parties, other witnesses, a vendor or contractor, or anyone that can provide important information?)

WHERE exactly did the events occur? Please be as specific as possible regarding location

WHAT happened? Explain in detail all you know about the accident

HOW did the event occur?

WHY in your opinion did the event occur?

RECOMMENDATIONS: HOW in your opinion could the incident have been prevented and WHAT is needed to be done to prevent future incidents?

My signature below acknowledges that I have been completely truthful with all I know about this incident at this time. I will immediately forward additional information to management as it may further appear to me.

Signature of Employee : _____ Date: _____

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Expertise is no accident

Key Risk Management Services
First Report of Injury
24-Hour Client Service Call Center: 866.847.8872; Fax: 888.576.7329

Employer

Employer's Name: ***Center for Social Change, Inc.***	Policy Number:
Employer's Address: ***6600 Amberton Drive, Elkridge, MD 21075***	Federal Employer Identification Number (FEIN):

Time and Place of Accident:

In what state & county did the accident occur? State: County:	Is this the state in which the employee is regularly employed? ☐Yes ☐No	Location of Injury:
Date of Injury:	Time of occurrence ☐A.M. ☐P.M.	Department:

Injured Employee

Name of Injured Employee:	Phone number:	Employee Classification: ☐FT ☐PT ☐Temp	
Address of Injured Employee:	Date of Birth:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single, Divorced, Widowed ☐ Separated ☐ Unknown
Social Security Number:	Number of dependents:		

Employment

Job Title:	Employee status: ☐Full Time ☐ Part Time☐	Date of hire:	State of hire:	
Average Weekly Wage:	Hours worked per day:	Days worked per week:	Pay Rate:	Pay rate is paid per: ☐ Hour ☐ Week ☐ Month
Was the employee paid for the day of injury? ☐ Yes ☐ No	Did salary continue? ☐ Yes ☐ No	Did injury occur on employer's premises? ☐ Yes ☐ No		
Were safeguards or safety equipment provided? ☐ Yes ☐ No		Were they used? ☐ Yes ☐ No		
Supervisor name:		Phone number:		

Incident

Is there more than one person injured or exposed? ☐ Yes ☐ No	Time employee began work on the date of injury: ☐A.M. ☐P.M.	Has employee returned to work? ☐ Yes ☐ No	First date employee failed to work a full day:
Date employee returned to work:		If fatal, date of death:	
Type of injury (e.g. Contusion; Fracture; Sprain):	Body part injured:	Cause of injury (e.g. Burn; Caught in; Fall; Struck by):	
How did the injury or illness occur?			

Treatment

Initial treatment/claim type (select one):
☐ Medical Record Only ☐ Minor: By Employer ☐ Minor Clinic/Hosp ☐ Emergency Care ☐ Hospitalized >24 hours ☐ Major Med/Lost Time

Physician name::	Physician address:	Physician phone:
Hospital:	Hospital address:	Hospital phone:

Submission

Witness name & phone number::	Date employer notified:	Date first report prepared:
Preparer's name:	Phone:	Title:
Comments:		

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Expertise is no accident

Supervisor Accident Investigation Report

Essentials
Risk Management

Everyone needs to work together and make every effort to minimize on-the-job injuries. If an injury does occur, it is important that Supervisors follow appropriate procedures to get timely medical care and conduct a thorough investigation to ultimately prevent future accidents. As soon as any needed medical needs are addressed, complete your review at the accident scene. Investigating incidents thoroughly helps us identify root causes and take corrective action to reduce the likelihood of repeat occurrences. The purpose of this review is not to assign blame, but rather to find facts. Safely secure the scene. Be prepared to take photos, measure, gather evidence, refer to written standards, and have witnesses complete written statements, etc. Determine: who, what, where, when, how, and why? Then assess what corrective actions should be taken, assign responsibility for those actions, and follow up on their completion. This form is intended for internal use and not to be used to report claims.

Report Completed by: (Supervisor): ***Date:***

Name of Injured Employee | Job Title | Employee Classification ☐ FT ☐ PT ☐ Temp | Branch/Jobsite Location of Injury

Injured Employee's Department | Date & Time Injury Occurred | Supervisor | Date & Time Reported to Supervisor

Task Performed when Injured | Exact Location of Injury Occurrence | Was Task (Check One): ☐ Routine ☐ Infrequent ☐ New | How long Employed?

When Did Injury Occur in Shift (Check One) ☐ Early ☐ Near Break ☐ Late ☐ OT

Occurred on Company Premises? ☐ Yes ☐ No

Injured Employee Experience in Job Task (Check One) ☐ New ☐ Novice ☐ Competent ☐ Expert ☐ Unauthorized

Date On-Scene Observation of Accident Site made by Supervisor?

Photos/Sketches Taken? ☐ Yes ☐ No

Any Witnesses? ☐ Yes ☐ No If Yes, attach Statements

Accident Evidence Secured? ☐ Yes ☐ No

Was Post-Accident Drug Testing Administered: ☐ Yes ☐ No If Yes, Where?

Physician/Hospital Authorized by Employer? ☐ Yes ☐ No Name

Has the injured employee and medical provider been informed that **transitional duty work** will be offered for immediate return to work within medical restrictions? ☐ Yes ☐ No

Additional Comments:

Nature of Injury and Body Parts Affected: (e.g., cut left thumb, broke right arm, strained lower back, etc.)

Severity of Injury/Illness.

- ☐ "Near-Miss" Accident (no injury)
- ☐ First-Aid (in house treatment only)
- ☐ Minor Medical (initial doctor treatment, then release)
- ☐ Serious (partial disability, continuing medical care)
- ☐ Catastrophic (hospitalization, critical condition, severe disability, fatality)

Work Status Following Initial Medical Treatment (Anticipated)

- ☐ Full Duty Return to work on next shift
- ☐ Transitional Duty Return to work on next shift
- ☐ Lost Time (did not return to work on next shift)

Cause of Injury/Illness.

- ☐ Slip/Trip/Fall onto same level
- ☐ Fall from above level (ledge, platform, ladder, stairs)
- ☐ Caught In/On/Between (pinched, snagged, grabbed)
- ☐ Overexertion (strain from force, exhaustion)
- ☐ Respiratory Exposure
- ☐ Struck-Against (hit on, bumped into)
- ☐ Struck By (hit by something/someone)
- ☐ Repetitive Motion Condition
- ☐ Vehicle Accident
- ☐ Cut by sharp object (knife, blade)
- ☐ Contact With (Electrical, Chemical, Heat/Cold)
- ☐ Foreign Material in Eye
- ☐ Bio-hazard Exposure (needle stick, blood)
- ☐ Animal/Insect Bite
- ☐ Other

Describe in Detail How the Accident Occurred.

Comment on equipment/tools, materials, people, vehicles, or environmental factors (such as noise, lighting, heat, cold, etc.) that may have contributed.

Protective Gear Used by Injured Employee (when incident occurred).

Specify any PPE worn at time of incident (e.g., hard hat, face shield, fall protection harness, respirator, gloves, etc.).

Immediate Causes of Accident (identify both behavior(s) and conditions(s). Check as many as applicable.

Behaviors/Work Practices

- ☐ Using Improper Equipment (wrong type/damaged)
- ☐ Abuse or Misuse of Equipment
- ☐ Removing Safety Devices or Making them Inoperable
- ☐ Failing to Use PPE or Seatbelts
- ☐ Improper Placement or Storage of Materials (unstable)

Physical Conditions

- ☐ Inadequate Guards/Barriers/Safety Devices
- ☐ Inadequate or Improper Protective Equipment
- ☐ Defective/Worn Tools or Equipment in Service
- ☐ Congested/Restricted Area/No Separation
- ☐ Fire or Explosion Hazard

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- ☐ Improper Handling Technique (help, grip, reach, posture)
- ☐ Failure to Use Safe Lift Handling Equipment (carts, lifts, etc.)
- ☐ Patient Handling/Improper Body Position or Overreaching
- ☐ Working on Equipment in Motion
- ☐ Performing Work at Unsafe Speed or Pace
- ☐ Not Authorized or Qualified to Perform Task
- ☐ Failure to Isolate/Secure/Lockout Energized Equipment
- ☐ Horseplay
- ☐ Inadequate Ventilation
- ☐ Drug/Alcohol Abuse
- ☐ Working Surface Unsafe (slippery, sloped)
- ☐ Poor Housekeeping/Disorder
- ☐ Noise/Vibration
- ☐ Hazardous Materials/Chemicals Used
- ☐ Visibility Inadequate (dark, glare, obscured)
- ☐ Heavy Work Uncontrolled
- ☐ Production Pace Unsafe
- ☐ Emergency Systems/Provisions inadequate
- ☐ Temperature Extremes
- ☐ Poor Traffic Flow

Root causes of Accident (identify both personal factor(s) and management practice factor(s). Check as many as applicable.

Possible Personal Factors

- ☐ Insufficient Knowledge
- ☐ Insufficient Skill
- ☐ Insufficient Experience
- ☐ Insufficient Motivation
- ☐ Fatigue (mental or physical)
- ☐ Personal Issues
- ☐ Other:

Possible Management Practice Factors

- ☐ Leadership/Supervision/Enforcement
- ☐ Engineering/Design/Capacity/Containment
- ☐ Process/Work methods
- ☐ Maintenance/Inspection Program
- ☐ Staffing/Manpower/Hiring Practices
- ☐ Tools/Equipment Provided
- ☐ Hazardous Materials Alternatives/Controls
- ☐ Training/Development
- ☐ Hazard Identification/Evaluation

Other/Comments:

Preventative Measures to Consider. Check as many as applicable.

- ☐ General Enforcement Improvement
- ☐ Training or Re-Training of Employees
- ☐ Individual Corrective Counseling
- ☐ PPE Improvement
- ☐ Staffing/Hiring Stds./Development
- ☐ Rotation of Employees
- ☐ Employee Awareness/Communication
- ☐ Job Re-Assignment of Employee(s)
- ☐ Housekeeping/Disposal improvement
- ☐ Substitute Safer Alternative Material
- ☐ Guards/Safety Devices Improvement
- ☐ Engineering/Process Improvement
- ☐ Visibility/Illumination Improvement
- ☐ Storage/Arrangement Improvement
- ☐ Provide Employee Incentive
- ☐ Remove Employee Disincentive
- ☐ Repair/Replace Equipment
- ☐ Congestion/Traffic Improvement
- ☐ Supply/Purchasing Improvement
- ☐ Insp./Maintenance Improvement
- ☐ Noise/Vibration Improvement
- ☐ Emergency Systems/Provisions
- ☐ Safety Efforts Effectiveness
- ☐ Warning System Provided
- ☐ Formal Procedure Devep/Update
- ☐ Work Method Improvement
- ☐ Workstation Re-Design
- ☐ Temperature Improvement
- ☐ Ventilation Improvement
- ☐ Discontinue/Eliminate Task
- ☐ Remove/Eliminate Hazard
- ☐ Conduct Hazard Analysis

Other/Comments:

Specific Corrective Action(s) Taken	*Person(s) Responsible*	*Target Date*	*Date Completed*

Report Corrective Action(s) Updates Completed by: (Supervisor): ***Date:***

Manager:
Comments

Executive:
Comments

Safety Committee:
Comments

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