INCIDENT ANALYSIS FORM

1. Incident analysis helps you in reducing or preventing future occupational injuries and illnesses.
2. This form requests all the information that the DWC says you must record for each on-the-job injury, fatality, and occupational disease. Employers must keep injury records for five years after the last day of the year in which the injury occurred.

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| **This is an** | **◼ Injury** | **◼ Disease** | **◼ Fatality** | **◼ Near-miss** |

**TODAY'S DATE**

**DATE REPORTED**

**COMPANY**

**DEPARTMENT**

**SUPERVISOR**

**PHONE NO.**

|  |  |  |  |  |  |  |
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| **1. Name of Person Involved** | | **2. Sex** | **3. Social Security Number** | | **4. DOB** | **5. Date of Incident** |
| **6. Home Address**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **7. Time and Day of Incident**  **\_\_\_\_\_\_\_ a.m; \_\_\_\_\_\_\_ p.m; day of week \_\_\_\_** | | | **8. Specific Location of Incident**  **Was it on employer’s premises? 🞏 yes 🞏 no** | | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Phone ( )** | **9. Employee’s Occupation** | | | **10. Job Task at Time of Incident** | | |
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| **13. Name and Address of Treating Physician**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **11. Length of Service**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_Years; \_\_\_\_\_\_\_\_\_\_\_ Months** | | | 1. **Employee was Working**   **🞏 Alone 🞏 With Fellow Workers**  **🞏 Other** | | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Phone ( )** | **14. Employment Category**  **🞏 Regular, full-time 🞏 Temporary**  **🞏 Regular, part-time 🞏 Non-employee**  **🞏 Seasonal** | | | **15. Experience in Occupation at Time of Incident**  **🞏 Less than 1 month 🞏1 to 5 month**  **🞏 6 months to 1 year 🞏 1 to less than 5 years**  **🞏 5 or more years** | | |
| 1. **Name and Address of Hospital**   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 1. **Phase of Employee’s Workday at Time of Injury**   **🞏 During break period 🞏 During meal period 🞏 Working overtime**  **🞏 Entering or leaving the building 🞏 Performing work duties 🞏 Other (explain below)** | | | | | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 1. **Name of employee’s immediate Supervisor at time of incident Witnessed Incident?**   **🞏 Yes 🞏 No** | | | | | |
| **19. Employee’s Wage (pay per Hour)** | **20. Other Witnesses** | | | | | |
| **21. Voluntary benefits paid by the employer, if any** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |

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| **22. PART of BODY INFURIED or AFFECTED** |

**🞏 Skull, Scalp 🞏 Jaw 🞏 Abdomen 🞏 Shoulder 🞏 Wrist 🞏 Knee 🞏 Foot**

**🞏 Eye 🞏 Neck 🞏 Back 🞏 Upper Arm 🞏 Hand 🞏 Thigh 🞏 Toe**

**🞏 Nose 🞏 Spine 🞏 Pelvis 🞏 Elbow 🞏 Finger 🞏 Lower Leg 🞏 Ankle**

**🞏 Mouth 🞏 Chest 🞏 Other Body Part 🞏 Forearm 🞏 Hip 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **23. NATURE of INJURY or ILLINESS** |

**🞏 Puncture 🞏 Bruise, Contusion 🞏 Skin Disorder 🞏 Amputation 🞏 Muscle Sprain 🞏 Cumulative Trauma Disorder**

**🞏 Laceration 🞏 Dislocation 🞏 Burn 🞏 Insect/Animal Bite🞏 Muscle Strain 🞏 Irritation**

**🞏 Fracture 🞏 Abrasion 🞏 Respiratory 🞏 Foreign Body 🞏 Hernia 🞏 Infection**

**🞏 Heat/Cold Stress 🞏 Hearing Loss 🞏 Chemical Exp. 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **24. DISPOSITION** | **25. DIAGNOSIS** | **26. SEVERITY** |
| **🞏 Days away from work # \_\_\_\_\_\_\_\_\_\_.**  **🞏 Restricted work days # \_\_\_\_\_\_\_\_\_\_\_.**  **🞏 Date returned to work # \_\_\_\_\_\_\_\_\_\_.**  **Sent to: 🞏 Doctor 🞏 Hospital** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **🞏 First Aid 🞏 Medical Treatment**  **🞏 Lost Work Days 🞏 Fatality**  **🞏 Other: Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **27. WHAT CONDITION of TOOLS, EQUIPMENT, or WORK AREA CONTRIBUTED TO INCIDENT?◼Not Applicable** | | |

**🞏 Close Clearance/Congestion 🞏 Floors/Work Surfaces 🞏 Inadequate Housekeeping 🞏 Defective Tools/Equipment/Vehicle**

**🞏 Hazardous Placement 🞏 Inadequate Ventilation 🞏 Equipment Failure 🞏 Illumination**

**🞏 Inadequate Warning System 🞏 Equipment/Workstation Design 🞏 Inadequate Guards/Barrier 🞏 Inadequate/Improper P.P.E.**

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| **28. WHAT CAUSED or INFLUENCED SUBSTANDARD CONDITIONS? ◼No Substandard Conditions** |

**🞏 Abuse or Misuse 🞏 Inadequate Supervision 🞏 Inadequate Purchasing 🞏 Inadequate Engineering**

**🞏 Inadequate Maintenance 🞏 Inadequate Tools/Equip..Mat. 🞏 Improper Work Surfaces 🞏 Wear and Tear**

**🞏 Lack of Knowledge/Training 🞏 Improper Motivation 🞏 Inadequate Capacity 🞏 Lack of Skill**

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| **29. WHAT ACTION or INACTION CONTRIBUTED to the INCIDENT? ◼Not Applicable** |

**🞏 Failure to Make Secure 🞏 Under Influence Drugs/Alcohol 🞏 Failure to Warn/Signal 🞏 Inadequate/Improper P. P. E. Use**

**🞏 Nullified Safety/Control Devices 🞏 Used Defective Equipment 🞏 Horseplay/Distractive Active 🞏 Operating at Improper Speed**

**🞏 Used Equipment Improperly 🞏 Improper Lifting 🞏 Operating Procedure Deviation**

**🞏 Running/Rushing/Acting in Haste 🞏 Improper Loading 🞏 Unauthorized Actions 🞏 Used Wrong Tool/Equipment**

**🞏 Improper Technique 🞏 Improper Position 🞏 Servicing/Operating Equipment**

**🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **30. PROBABLE RECURRENCE** | **31. LOSS SEVERITY POTENTIAL** |
| **🞏 Frequent 🞏 Occasional 🞏 Rare** | **🞏 Major 🞏 Serious 🞏 Minor** |
| **32. PREVENTIVE MEASURES: (What corrective actions have been taken or are planned to prevent a recurrence?)** | |

**🞏 Improve Enforcement 🞏 Improve Clean-up Procedures 🞏 Repair/Replace Equipment 🞏 Corrective Counseling**

**🞏 Improve Storage/Arrangement 🞏 Rotation of Employee 🞏 Eliminate Congestion 🞏 Improve/Change Work Method**

**🞏 Identify/Improve P. P. E 🞏 Install/Revise Guards/Devices 🞏 Task Analysis to Be Completed**

**🞏 Task Analysis/Procedure Revision 🞏 Improve Design/Construction 🞏 Job Reassignment of Employees**

**🞏 Use Other Materials/Supplies 🞏 Improve Illumination 🞏 Mandatory Pre-Job Instructions**

**🞏 Improve Ventilation 🞏 Reinstruction of Employees 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **33. EMPLOYEE’S DESCRIPTION of INCIDENT (Attach sheet for additional comments) ◼ Comments sheet** |

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| **34. SUPERVISOR’S DESCRIPTION of INCIDENT (Attach sheet for additional comments) ◼ Comments sheet** |

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| **35. SPECIFIC CORRECTIVE ACTIONS or PREVENTIVE MEASURES TAKEN** | | | |
| **Corrective Action Taken** | **Person Responsible** | **Target Date** | **Date Completed** |
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Supervisor’s Signature Date