Employee's Name: **Incident Date:**

INSTRUCTIONS TO THE SUPERVISOR – INVESTIGATION PROCEDURE

- ⇨ **Complete this report with full detail. Fax a completed copy to MPA at (925) 946-4183.**
- ⇨ Return the original completed report to your Human Resources Department within 72 Hours of the day you first became aware of the injury or illness.
- ⇨ Conduct a walk through of the accident location as needed to gain an understanding of how the incident occurred.
- ⇨ Interview and get signed statements from the injured employee and witnesses at the scene, if appropriate. Use the attached EMPLOYEE/WITNESS ACCOUNT OF ACCIDENT form.
- ⇨ Take photographs or make a sketch of the accident scene as needed, and attach to report.
- ⇨ Ensure hazardous conditions are corrected immediately. Isolate and restrict access to accident-related equipment, areas, etc, as needed.
- ⇨ **Develop appropriate corrective measures to prevent this incident from recurring, and list on this report.**

SUPERVISOR TO COMPLETE:

1. **Employee's usual shift: to (use 24 hour format, i.e. 6:00pm = 18:00)**
2. **Time employee started work on day of injury:**
3. **Time of accident/injury:**
4. **Extended shift/overtime on day of injury?** ☐ Yes ☐ No
5. **ROOT CAUSE ANALYSIS: Which of the following may have caused or were underlying factors that resulted in the incident? (Check all that apply)**

PEOPLE Factors					
☐	Employee Training / Instruction	☐	Operating without authority	☐	Correct tool not used
☐	Distraction, inattention	☐	Operating at unsafe speeds	☐	Improper Motivation
☐	Fatigue / Condition of Individuals	☐	Incorrect lifting, carrying	☐	Bypassing safety devices
☐	PPE not utilized	☐	Taking unsafe position / posture	☐	Combative Person / Actions of Others
☐	Staffing shortage	☐	Tool used improperly	☐	Other (list)

EQUIPMENT, MATERIALS or ENVIRONMENT					
☐	Lighting too much / too little	☐	Proper tool not available	☐	HVAC / ventilation maintenance
☐	Guard / safety device missing	☐	Tools / equipment malfunction	☐	Motor Vehicle maintenance
☐	Unstable load/ Storage/ Congestion	☐	Inadequate work space	☐	Walking surface unsafe
☐	PPE unavailable	☐	Chemical Used (attach MSDS)	☐	Other (list)

PROCESSES & PROCEDURES					
☐	No warning system	☐	S.O.P. not followed	☐	Inadequate Traffic Control
☐	No warning provided / posted	☐	S.O.P. contributed	☐	Operational tactics
☐	Spills, debris, housekeeping inadequate	☐	No procedure in place	☐	Other (list)

6. Do you agree with the Triage Description and Employee/Witness statements? ☐ **Yes** ☐ **No**

⇨ **If not, please describe your understanding of the events that resulted in injury or occupational illness, including tasks assigned**.

7. Were other employees also injured? ☐ **Yes** ☐ **No**

⇨ **If YES, list names**:

Corrective Action

What action will be taken to prevent recurrences of this incident? (Check as many as necessary):

☐	Request ergonomic evaluation	☐	Install, replace, adjust guards	☐	Provide/monitor protective equip
☐	Train Staff	☐	Modify, replace tools, equipment	☐	Repair (explain below)
☐	Improve emergency system	☐	Provide inspections, observations	☐	Revise equipment, layout
☐	Improve housekeeping	☐	Personal Safety Coaching	☐	Review at roll call / staff mtg.
☐	Improve job orientation	☐	Develop, revise operating procedure	☐	**No action taken/Other (explain below)**

Follow Up on Corrective Action

1. **Specific Action taken:**
   a. **Work or Purchase Order to correct condition?** ☐ **Yes – Order #:** ☐ **No**
   b. **Operating procedure change?** ☐ **Yes** ☐ **No**
   ⇨ **If YES, description:**
2. **Other Comments – explain:**
3. **PHOTOGRAPHS OR SKETCH ATTACHED?** ☐ **Yes** ☐ **No**
4. **Employee/Witness statement(s) attached?** ☐ **Yes** ☐ **No**
5. **No Action Taken – explain:**

Supervisor's Name:

Supervisor's Signature: **Date:**

Management Review – I have reviewed this report and its findings.

Division / Department Head: **Date:**

Fax a copy of the completed report to Municipal Pooling Authority 925-946-4183.

EMPLOYEE/WITNESS ACCOUNT OF ACCIDENT

Note: PRINT this form, have completed and forward along with the Accident Investigation Report.

Use one form per person – CHECK below as noted:

☐ **Injured Employee** ☐ **Witness (City/Town Employee?** ☐ **Yes** ☐ **No**

Name: _____ **Department:** _____

Today's Date: _____ **Date/Time of Accident:** _____/_____

Location of Accident: _____

Accident Description (explain in detail what you were doing immediately prior to the accident and then how you believe the accident happened):

_____
Signature

Name(s) of Other Witness(s) to Accident:

1. _____

2. _____

3. _____

ATTACH TO THE ACCIDENT INVESTIGATION REPORT

Fax a copy of the completed report to Municipal Pooling Authority 925-946-4183.