ACCIDENT INVESTIGATIONS

All accidents that result in injury to workers, regardless of their nature, shall be investigated and reported. It is an integral part of any safety program that documentation takes place as soon as possible so that the cause and means of prevention can be identified to prevent a reoccurrence.

In the event that an employee falls or there is some other related, serious incident occurring, this plan shall be reviewed to determine if additional practices, procedures, or training need to be implemented to prevent similar types of falls or incidents from occurring.

CHANGES TO PLAN

Any changes to the plan will be approved by the Safety Director. This plan shall be reviewed by a qualified person as the job progresses to determine if additional practices, procedures or training needs to be implemented by the competent person to improve or provide additional fall protection. Workers shall be notified and trained, if necessary, in the new procedures. A copy of this plan and all approved changes shall be maintained at the jobsite, and office.

SECTION V

INCIDENT/ACCIDENT INVESTIGATION FORM

Company Name:_____

Address:_____

Name of injured person:_____

Sex: M___F___ Age:_____

Date of injury:_____ Time of injury_____

Where did accident occur?_____

On Company premises? ___Y ___N

Body part(s) Injured:_____

_____

Type of Injury (burn, cut, abrasion, sprain, crush, etc.)_____

_____

Describe how the injury occurred:_____

_____

_____

Was first aid administered? ___Y ___N

Was employee drug/alcohol tested? ___Y ___N

If not, why not?_____

_____

Who administrated first aid?_____

Name/Address/Telephone:_____

(F001)

What treatment was administered?_____

Was professional medical treatment administered? ___Y ___N

Name of provider: _____

Was 911 or a local emergency number called? ___Y ___N

If yes, by whom?_____ At what time?_____

Describe any non medical actions taken:_____

_____

_____

Injured party left scene:

___on foot ___ambulance ___in personal vehicle

___other

Draw a diagram of the accident/incident below. Attach a separate page or use the back of this sheet if needed:

What were the immediate causes that may have lead to the accident?

Were photographs, video or other supporting data collected?

Indicate the names of any other people interviewed:

What actions and / or conditions caused or may have caused the accident?

What corrective actions could be implemented in order to prevent this from happening again?

Name of person completing this form (name, address, home and work telephone #'s)

Signature:_____ Date:_____

Indicate on the lines below the names of the employees authorized to conduct accident investigation analysis:

_____

_____

_____

_____

_____

INJURED WORKER FOLLOW-UP FORM

Date:_____

Dear_____

As a valued employee of J & B Acoustical, Inc., we are most interested in your speedy recovery and return to employment with us. As such, we wish to ask your cooperation in the following areas:

1. Please notify us as soon as possible as to your probable return to work date once this has been determined by your attending physician.
2. If your physician questions your present ability (given your physical restrictions) to perform your regular job functions, please ask him to list the job duties that you can perform. There is a possibility that a "job modification" could be arranged to assist you in an earlier return to work date.

We appreciate your continued effort and look forward to seeing you back on the job. If we can assist you in any way, please give us a call. In the meantime, please discuss the above questions with your attending physician and communicate his thoughts, either verbally or in a written form to us.

Thank you,

HR Manager

Ohio | Bureau of Workers' Compensation

Accident Report

Employer name	Policy number
Employee name	Date of injury
Claim number	Report date
Report completed by	
Job title	

Manner of Accident: *(check one)*

- ☐ Contact with objects or equipment
- ☐ Falls
- ☐ Bodily reaction and exertion (including repetitive motion, lifting, etc.)
- ☐ Exposure to harmful substances or environments
- ☐ Transportation accidents
- ☐ Fires and explosions
- ☐ Assaults and violent acts
- ☐ Other

Fully describe the accident:

Causal factors that contributed to accident: (Check all that apply and provide detailed description.)

☐ **Environment:** (weather, housekeeping, lighting, noise, temperature, etc.)

Explain: _____

☐ **Human factor/Personal:** (level of experience, level of training, physical capability, health, fatigue, stress, etc.)

Explain: _____

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Causal factors that contributed to accident: (Check all that apply and provide detailed description.)

☐ **Task:** (ergonomics, condition changes, work process, safe work procedures, etc.)

Explain: _____

_____

☐ **Management/Process:** (safety policies, enforcement, supervision, hazard correction, preventative maintenance, etc.)

Explain: _____

_____

☐ **Material/Equipment:** (equipment failure, design, guarding, hazardous substances, etc.)

Explain: _____

_____

Preventative measures to be implemented: (Check all that apply.)

☐ **Engineering control:** (Design the facility, equipment, or process to eliminate or reduce exposure to a hazard.)

☐ **Administrative control:** (any procedure that minimizes exposure by controlling the manner in which work is performed or manipulation of the work schedule)

☐ **Personal protective equipment** (PPE): (reduces employee exposure to hazards when engineering and administrative controls are not feasible or effective in reducing these exposures to acceptable levels)

Fully describe the specific actions that have or will be taken to prevent a similar accident from occurring again. Corrective actions should address causal factors identified above.

_____

_____

_____

_____

_____

X _____ _____

Signature Date signed