

KLAMATH FALLS CITY SCHOOLS

SUPERVISOR'S INCIDENT ANALYSIS REPORT

(Fact-finding Not Fault-finding)

EMPLOYEE _____
DEPARTMENT _____
INCIDENT LOCATION _____
DATE OF INCIDENT _____
INCIDENT REPORTED TO _____
DATE INCIDENT REPORTED _____

JOB TITLE _____
DATE OF HIRE _____
SUPERVISOR _____
TIME OF INCIDENT _____
HOW REPORTED _____
TIME REPORTED 801 FILED? Y () N ()

<u>PART(S) OF BODY AFFECTED</u>		
<u>Head/Neck</u>	<u>Left Side</u>	<u>Right Side</u>
() Scalp	()	()
() Neck	()	()
() Ears	()	()
() Eyes	()	()
() Mouth	()	()
() Teeth	()	()
() Face	()	()
<u>Upper Extremities</u>	<u>Left Side</u>	<u>Right Side</u>
() Shoulder	()	()
() Upper Arm	()	()
() Elbow	()	()
() Forearm	()	()
() Wrist	()	()
() Hand	()	()
() Fingers	()	()
<u>Lower Extremities</u>	<u>Left Side</u>	<u>Right Side</u>
() Thigh	()	()
() Lower Leg	()	()
() Knee	()	()
() Ankle	()	()
() Foot/Toes	()	()
<u>Trunk</u>	<u>Left Side</u>	<u>Right Side</u>
() Lower Back	()	()
() Upper Back	()	()
() Chest	()	()
() Abdomen	()	()
() Hip	()	()
() Groin	()	()

<u>NATURE OF INCIDENT</u>	
() Cut	() Foreign Body in Eye or Sliver
() Scrape	() Burn
() Bruise	() Electric Shock
() Skin Rash	() Pain in Body Part Identified at Left
() Difficulty Breathing	() Jammed Finger or Toe
() Numbness	() Inflammation
Has employee injured this part(s) of the body previously or is there any pre-existing condition that could affect injury? Y () N () Identify:	

<u>CONTRIBUTING FACTORS</u>
() Machinery Defect (Save defective parts & pieces)
() Tool or Equipment Broke (Save broken parts & pieces)
() Equipment Guarding
() Proper Tools/Equipment Not Available
() Floor, Work Surface, or Walking Surface
() Housekeeping
() Lighting
() Clothing or Jewelry

<u>WORK BEHAVIOR AT TIME OF INCIDENT</u>
<i>(Please check all items that pertain)</i>
() Lifting
() Carrying
() Reaching
() Pushing
() Pulling
() Bending or Twisting (circle correct item)
() Running
() Stepping (walking or moving from one level to another)
() Typing
() Other Repetitive Motion Tasks
() Jumping
() Driving (If so, what vehicle?)
() Operating Equipment
() Innocent Bystander
() Other _____

SAFETY EQUIPMENT IN USE

- Gloves
- Respirator
- Face Shield
- Seat Belt
- Apron
- Safety Glasses/Goggles

EXPLAIN WHAT EMPLOYEE WAS DOING JUST PRIOR TO & AT THE TIME OF THE INCIDENT
 (USE SEQUENCE OF EVENTS. PLEASE BE SPECIFIC)

HOW LONG HAS EMPLOYEE WORKED AT THIS SPECIFIC JOB?

HAVE THERE BEEN NEAR-MISSES OR MINOR INCIDENTS IN THIS SAME ACTIVITY? HAS ANY ACTION
 BEEN TAKEN?

WHAT DOES EMPLOYEE THINK CAN BE DONE TO PREVENT RECURRENCE?

SUPERVISOR'S COMMENTS ON CORRECTIVE ACTION:

PROVIDE WITNESS INFORMATION ON SEPARATE PAPER

Injured Employee's Signature	DATE
Supervisor's Signature	DATE
Manager's Signature	DATE

SAFETY COMMITTEE EVALUATION

CORRECTIVE ACTION NEEDED

- Improve Design
- Improve Housekeeping
- Safety Devices
- Pers. Prot. Equipment
- Repair or Replace Equip.
- More Direct Supervision
- Job Safety Analysis
- Maintain Clean Work Area
- Training
- Establish Rule/Procedures
- Discipline (Rule Enforcement)

SAFETY EQUIPMENT

- Availability of Equipment
- Proper Equipment
- Not in Use
- Training Required

SAFETY RULES

- Adequate
- Inadequate
- Not Understood
- Enforcement Issue

RECOMMENDATION(S):