Klamath Falls City Schools SUPERVISOR;S INCIDENT ANALYSIS REPORT (Fact-finding Not Fault-finding)

NAME OF SCHOOL:_____

Employee Name:	**Job Title:**
Department:	**Date of Hire:**
Incident Location:	**Supervisor:**
Date of Incident: **Time:** **AM** **PM**	**How Reported:** ☐ **Verbal** ☐ **Written**
Date Incident Reported: **Time:** **AM** **PM**	**801 Filed?** ☐ **Yes** ☐ **No**
Incident Reported To:	**Parent Instructions:**

PART(S) OF BODY AFFECTED

Head/Neck	**Left Side**	**Right Side**
☐ Scalp	☐	☐
☐ Neck	☐	☐
☐ Ears	☐	☐
☐ Eyes	☐	☐
☐ Mouth	☐	☐
☐ Teeth	☐	☐
☐ Face/Forehead	☐	☐
Upper Extremities	**Left Side**	**Right Side**
☐ Shoulder	☐	☐
Upper Arm	☐	☐
☐ Elbow	☐	☐
☐ Forearm	☐	☐
☐ Wrist	☐	☐
☐ Hand	☐	☐
☐ Fingers	☐	☐
Lower Extremities	**Left Side**	**Right Side**
☐ Thigh	☐	☐
☐ Lower Leg	☐	☐
☐ Knee	☐	☐
☐ Foot/Toes	☐	☐
Trunk	**Left Side**	**Right Side**
☐ Lower Back	☐	☐
☐ Upper Back	☐	☐
☐ Chest	☐	☐
☐ Abdomen	☐	☐
☐ Hip	☐	☐
☐ Groin	☐	☐

NATURE OF INJURY (Check One)

☐ Allergies	☐ Dizzy	☐ Scrape/Scratch
☐ Bee Sting	☐ Electric Shock	☐ Seizure
☐ Bite	☐ Fall	☐ Slip
☐ Blood Exposure	☐ Hit	☐ Splash
☐ Break	☐ Jammed	☐ Strain
☐ Burn	☐ Kick	☐ Trip
☐ Choking	☐ Pinch/Smash	☐ Twist
☐ Collide	☐ Puncture	
☐ Cut/Gouge	☐ Pushed	
☐ Other (explain)		

CONTRIBUTING FACTORS

☐ Machinery defect (save defective parts/pieces)	☐ Tool or equipment broke (save broken parts/pieces)	☐ Proper tools/equipment not available
☐ Floor, work surface, walking surface	☐ Housekeeping	☐ Clothing or Jewelry
☐ Lighting		

WORK BEHAVIOR AT TIME OF INCIDENT (Check all that pertain)

☐ Lifting	☐ Carrying	☐ Reaching
☐ Pushing	☐ Pulling	☐ Bending
☐ Twisting	☐ Running	☐ Typing
☐ Jumping	☐ Bystander	☐ Sitting
☐ Driving (what vehicle?)	☐ Other repetitive motion tasks	☐ Operating equipment
☐ Stepping, walking or moving from one level to another		

SAFETY EQUIPMENT IN USE

☐ Glove ☐ Face Shield ☐ Apron ☐ Respirator ☐ Seat blet ☐ Safety glasses/goggles

EXPLAIN WHAT EMPLOYEE WAS DOINGJUST 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 PREVIOUS ACTION BEEN TAKEN?

WHAT DOES EMPLOYEE THINK CAN BE DONE TO PREVENT RECURRENCES?

SUPERVISORS COMMENTS ON CORRECTIVE ACTION:

PROVIDE WITNESS INFORMATION ON A 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 equipment	☐ More direct supervision	☐ Job safety analysis	☐ Maintain clean work area
☐ Training	☐ Establish rules and procedures	☐ Discipline (rule enforcement)	

SAFETY EQUIPMENT

☐ Availability of equipment	☐ Proper equipment	☐ Not in use	☐ Training required

SAFETY RULES

☐ Adequate	☐ Inadequate	☐ Not understood	☐ Enforcement issue

RECOMMENDATIONS: