# *KLAMATH FALLS CITY SCHOOLS*

SUPERVISOR'S INCIDENT ANALYSIS REPORT

(Fact-finding Not Fault-finding)

| | |
|---|---|
| EMPLOYEE | JOB TITLE |
| DEPARTMENT | DATE OF HIRE |
| INCIDENT LOCATION | SUPERVISOR |
| DATE OF INCIDENT | TIME OF INCIDENT |
| INCIDENT REPORTED TO | HOW REPORTED |
| DATE INCIDENT REPORTED | TIME REPORTED 801 FILED? Y ◯ N ◯ |

## PART(S) OF BODY AFFECTED

| Head/Neck | Left Side | Right Side |
|---|---|---|
| ( ) Scalp | ( ) | ( ) |
| ( ) Neck | ( ) | ( ) |
| ( ) Ears | ( ) | ( ) |
| ( ) Eyes | ( ) | ( ) |
| ( ) Mouth | ( ) | ( ) |
| ( ) Teeth | ( ) | ( ) |
| ( ) Face | ( ) | ( ) |

| Upper Extremities | Left Side | Right Side |
|---|---|---|
| ( ) Shoulder | ( ) | ( ) |
| ( ) Upper Arm | ( ) | ( ) |
| ( ) Elbow | ( ) | ( ) |
| ( ) Forearm | ( ) | ( ) |
| ( ) Wrist | ( ) | ( ) |
| ( ) Hand | ( ) | ( ) |
| ( ) Fingers | ( ) | ( ) |

| Lower Extremities | Left Side | Right Side |
|---|---|---|
| ( ) Thigh | ( ) | ( ) |
| ( ) Lower Leg | ( ) | ( ) |
| ( ) Knee | ( ) | ( ) |
| ( ) Ankle | ( ) | ( ) |
| ( ) Foot/Toes | ( ) | ( ) |

| Trunk | Left Side | Right Side |
|---|---|---|
| ( ) Lower Back | ( ) | ( ) |
| ( ) Upper Back | ( ) | ( ) |
| ( ) Chest | ( ) | ( ) |
| ( ) Abdomen | ( ) | ( ) |
| ( ) Hip | ( ) | ( ) |
| ( ) Groin | ( ) | ( ) |

## NATURE OF INCIDENT

| | |
|---|---|
| ( ) Cut | ( ) Foreign Body in Eye or Sliver |
| ( ) Scrape | ( ) Burn |
| ( ) Bruise | ( ) Electric Shock |
| ( ) Skin Rash | ( ) Pain in Body Part Identified at Lef |
| ( ) 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:

## CONTRIBUTING FACTORS

( ) 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

## WORK BEHAVIOR AT TIME OF INCIDENT

*(Please check all items that pertain)*

( ) 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
( ) Face Shield
( ) Apron
( ) Respirator
( ) Seat Belt
( ) 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
( ) Repair or Replace Equip.
( ) Training
( ) Improve Housekeeping
( ) More Direct Supervision
( ) Establish Rule/Procedures
( ) Safety Devices
( ) Job Safety Analysis
( ) Discipline (Rule Enforcement)
( ) Pers. Prot. Equipment
( ) Maintain Clean Work Area

SAFETY EQUIPMENT

( ) Availability of Equipment
( ) Proper Equipment
( ) Not in Use
( ) Training Required

SAFETY RULES

( ) Adequate
( ) Inadequate
( ) Not Understood
( ) Enforcement Issue

**RECOMMENDATION(S):**