Accident Investigation Report

General Incidents, Injuries, and Workers' Compensation Claims

Employee Information

Employee's Name:	SCWA ID #:	Phone Number:
Supervisor's Name:		Job Title:

Incident Information (Completed by Employee)

Date of Injury: ___/____/____ **Time of Injury:** ___:___ AM PM

Date Reported: ___/____/____ **Time Reported:** ___:___ AM PM

Reported to a supervisor within 24 hrs?: ☐ YES **Reported to:** _____ ☐ NO

Address of the Incident Site:

Street/Building _____

City _____ Zip Code _____

☐ Outdoors/Yard ☐ Pump Station ☐ Indoors/Building ☐ Residential/Excavation/Service

Description of the Injury/Incident Severity Characteristics

Body Part Injured: ☐ LEFT ☐ RIGHT

☐ Head ☐ Face ☐ Mouth ☐ Shoulder ☐ Elbow ☐ Hand ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle ☐ Back:Upper/Mid/Lower
☐ Neck ☐ Eye ☐ Abdomen ☐ Arm ☐ Forearm ☐ Finger(s):_____ ☐ Thigh ☐ Lower Leg ☐ Foot ☐ Toe(s): _____

Injury Type (check all that apply):

☐ Insect Bite ☐ Bruise/Swelling ☐ Cut/Laceration ☐ Burn ☐ Head Injury ☐ Hearing Loss ☐ Electrocution ☐ Internal Damage
☐ Poison Ivy ☐ Sprain/Strain ☐ Dislocation ☐ Fracture ☐ Abrasion/Scrape ☐ Occupational ☐ Other:_____

Injury Cause (check all that apply):

☐ Environmental ☐ Fall from Height ☐ Body Movement ☐ Chemical ☐ Struck by Moving Object ☐ Impact/Body Part Hitting Fixed Object
☐ Slip/Trip/Fall ☐ Sharp Object ☐ Repetitive Motion ☐ Electrical ☐ Noise/Sound ☐ Other:_____

Thoroughly describe how and why the incident happened:

Name(s) of Witness:_____

Are you: ☐ Left-handed ☐ Right-handed

Did you finish your entire shift the day of the incident? ☐ YES ☐ NO

Have you ever been treated for a similar injury or condition? ☐ YES ☐ NO **If so, Approx. Date : ___ /_____**

Medical Treatment

Treatment: ☐ NONE ☐ Hospital ☐ Walk-In Clinic ☐ Doctor's Office

Doctor's Name:

Treatment Center Address:

Street_____ City _____ Zip Code _____

Supervisor's Investigation

Was the employee in the scope of his/her regular or assigned job task(s)? ☐ YES ☐ NO **(Explain Below)**

If no, why?

Contributing Factors (check all that apply):

☐ Inexperience ☐ Unsafe Act ☐ Lifting/Pulling ☐ Defective Equipment ☐ Procedure Not Followed
☐ Improper Tool ☐ No PPE Worn ☐ Heavy Equipment ☐ Lack of Equipment Utilization ☐ No Procedure Exists
☐ Uneven Surface ☐ Ice/Snow ☐ Tall Grass/Wooded ☐ Hand/Powered Tool ☐ No Training Provided
☐ Other:_____

How can we prevent the same incident from happening again?:

ONCE THIS FORM IS SIGNED & COMPLETED - SEND A COPY TO THE ACCIDENT REPORT EMAIL GROUP

By signing this form, employee and supervisor agree that this is an accurate representation of the accident. If the employee is represented by Local 393, by signing this form the employee authorizes the release of this form to Local 393. If the employee does not wish to release this information to Local 393, the employee must indicate same in writing.

Required Signatures

Employee's Signature: _____ **Date:** ___/____/____

Supervisor's Signature: _____ **Date:** ___/____/____