

# ORDER OF SAINT BENEDICT/COLLEGE OF SAINT BENEDICT

## Accident/Incident Report/Analysis

OSB Employee \_\_\_\_\_ CSB Employee \_\_\_\_\_

Employee Name (last, first, middle initial):		Employee Social Security No:		Date of Injury:	
Home Address (include street address, city, state, zip):		Campus Address/Dorm:		Home Phone Number: _____	
		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Campus/Dorm Extension: _____	
Occupation/Job Title:		Date of Hire:		Date of Birth:	
Regular Dept:		Work Extension:		Apprentice: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Employment Status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Student <input type="checkbox"/> Volunteer		Supervisors Name and Work Number:		Time Employee Began Work _____ AM / PM	
Department/Location of Accident: (include dept. & full address)		Date of first day of lost time:		Date employer notified of injury:	
		Return to work date:		Date employer notified of lost time:	
		Date of death:		Time of day of injury: _____ A.M. _____ P.M.	
On employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		DESCRIBE NATURE OF INJURY OR ILLNESS IN DETAIL, BE SPECIFIC (include part(s) of body affected, right or left, e.g. fractured arm, lead poisoning)			
DESCRIBE EMPLOYEE'S ACTIVITIES WHEN INJURY OCCURRED WITH DETAILS OF HOW EVENT OCCURRED (include name of other individuals involved, tools, machinery, objects, vapors, chemicals, radiation's, unnatural motions of employee)					
What object or substance directly harmed the employee? Ex: "concrete floor"; "chlorine". If this question does not apply to the incident, leave it blank.					
Was employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No			Was employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
First aid given by: (name, title and address)		Time of day:	Medical Examination: Hospital/Clinic (name and address)		Time of day:
Nature of Accident: Fell _____ Struck by _____ Tripped _____ Shock _____ Slipped _____ Burn _____ Caught in or between _____ Other _____		Witnesses name and phone number:			Date this form was prepared:
		Position employee was in before accident: (ie. standing, sitting)			
Lost time due to accident (Employee) _____					
Cumulative Lost Time (other than injured) _____					
Property Damaged Yes _____ No _____ If yes, explain: _____					

*Form MUST be forwarded to Human Resources within 24 hours of accident/incident*

**CAUSE:**

**Unsafe Acts:**

- Operating Without Authority \_\_\_\_\_
- Operating at Unsafe Speed \_\_\_\_\_
- Making Safety Devices Inoperative \_\_\_\_\_
- Using unsafe equipment or equipment unsafe \_\_\_\_\_
- Unsafe Loading, Placing, Mixing \_\_\_\_\_
- Taking Unsafe Position \_\_\_\_\_
- Working on Moving or Dangerous Equipment \_\_\_\_\_
- Distraction, Teasing, Horse Play \_\_\_\_\_
- Failure to Use Personal Protective Devices \_\_\_\_\_

**Unsafe Conditions:**

- \_\_\_\_\_ Inadequately guarded
- \_\_\_\_\_ Unguarded
- \_\_\_\_\_ Defective Tools, Equipment, or Substance
- \_\_\_\_\_ Unsafe Design or Construction
- \_\_\_\_\_ Hazardous Arrangements
- \_\_\_\_\_ Unsafe Illumination
- \_\_\_\_\_ Unsafe Ventilation
- \_\_\_\_\_ Unsafe Clothing

Why was the unsafe act committed? \_\_\_\_\_

Why did the unsafe condition exist? \_\_\_\_\_

Any pre-existing physical disabilities? \_\_\_\_\_

**GUIDES TO CORRECTIVE ACTION:**

Based on the cause checked above, indicate below the corrective action you are taking:

**UNSAFE ACT:**

- \_\_\_\_\_ Stop Worker
- \_\_\_\_\_ Study the Job
- \_\_\_\_\_ Instruct (Tell-show/Try-check)
- \_\_\_\_\_ Follow Up
- \_\_\_\_\_ Enforce

**UNSAFE CONDITION:**

- \_\_\_\_\_ Remove/Lockout
- \_\_\_\_\_ Guard
- \_\_\_\_\_ Warn
- \_\_\_\_\_ Recommendation to Maintenance Department
- \_\_\_\_\_ Recommendation to my Supervisor
- \_\_\_\_\_ Follow Up

What are you actually doing to prevent similar injuries? \_\_\_\_\_

What further recommendations? \_\_\_\_\_

**Employee:** \_\_\_\_\_ Title: \_\_\_\_\_ Telephone No: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature)

**Supervisor:** \_\_\_\_\_ Telephone No: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature)

**POST ACCIDENT REVIEW BY SAFETY OFFICER**

*Please check the appropriate responses:*

\_\_\_\_\_ Telephone Review by Safety Officer with Employee and Supervisor Completed \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_ Site Review by Safety Officer Completed \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_ Personal Review/Interview by Safety Officer with \_\_\_\_\_ completed \_\_\_\_\_, \_\_\_\_\_.  
(Supervisor, Employee, both)

\_\_\_\_\_ No further investigation necessary.

\_\_\_\_\_ Narrative Prepared by Safety Officer \_\_\_\_\_, \_\_\_\_\_ and attached.  
(Date)

\_\_\_\_\_ Narrative Not Necessary.

Safety Officer \_\_\_\_\_ Date Returned to HRO \_\_\_\_\_  
(Signature)