

# TOWN OF MILFORD

**ACCIDENT INVESTIGATION REPORT - AIR**

Claim # Click here to enter text. (To be filled in by HR Department)

Please do not use employee name or identifier. Simply use EE in reference to employee.

**Please fill in the following**

|  |  |
| --- | --- |
| Job Classification (Title): | Click here to enter text. |
| Years at this Job Classification: | Click here to enter text. |
| Date of Accident: | Click here to enter text. |
| Time of Accident: |  Click here to enter text. AM PM |
| Location of Accident: | Click here to enter text. |
| Witnesses: | Click here to enter text. |
| Type of Injury (Burn, Strain, Fracture, etc.) | Click here to enter text. |
| Injured Body Part (Identify if Upper, Lower, Left, Right, etc.) | Click here to enter text. |
| Was First Aid given? | Yes No |
| When and by whom? | Click here to enter text. |
| Did Injured leave work? | Yes No Click here to enter text. AM  PM |
| Date? | Click here to enter text. |
| Did injured go to doctor? | Yes No |
| Hospital? (If yes, which hospital?) | Yes No |
| Name of Physican (or ER or Urgent Care)? | Click here to enter text. |
| Return to Work Date (if known): | Click here to enter text. |

**Additional Forms completed:**

**Employee:** Yes No - Notice of Accidental Injury or Occupational Disease (8aWCA)

**Employer:** Yes No - Employer’s First Report of Occupational Injury or Disease (8WC) Supervisor’s

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Investigation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Comments:**

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| --- |
| Click here to enter text. |

**Incident Details**

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| 1.  | **WHAT HAPPENED?**  Describe why you are making this investigation. | Click here to enter text. |
| 2.  | **WHY DID IT HAPPEN?** Specific condition that caused the accident. | Click here to enter text. |
| 3.  | **IF VEHICLE RELATED INCIDENT WAS SEATBELT WORN AT TIME OF INCIDENT?**  | Yes No NOT VEHICLE RELATED |
| 4.  | **WAS APPROPRIATE PERSONAL EQUIPMENT BEING UTILIZED?** | Yes No N/AIF NO, IDENTIFY EQUIPMENT THAT SHOULD HAVE BEEN UTILIZED:Click here to enter text. |
| 5.  | **INDICATE WHICH OF THE FOLLOWING REQUIRE CORRECTIVE ACTION** (Please check item requiring corrective action) | **EQUIPMENT:**Selection Usage Arrangement Maintenance**MATERIAL:**Selection Handling Placement Processing**PEOPLE:**Selection Training Placement Leading |
| 6.  | **RECOMMENDED CORRECTIVE ACTION TO PREVENT RECURRENCE?** | Yes No N/A |
| 7.  | **WHAT CORRECTION ACTION HAVE YOU TAKEN THUS FAR?** Taken or recommend action, depending upon your authority. | Click here to enter text. |
| 8.  | **WAS ACCIDENT PREVENTABLE?** | Yes No IF YES, PLEASE EXPLAIN: Click here to enter text. |

**Lifting and Material Handling Analysis** **NOT APPLICABLE**

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| --- | --- | --- |
| 1. | What was being handled? | Click here to enter text. |
| 2. | How much did it weigh? | Click here to enter text. |
| 3. | What was the distance of the lift or lower? | Click here to enter text. |
| 4. | Did the employee slip while lifting? | Yes No  |
| 5. | Were there any abnormal working conditions at the location of the accident? (I.e. wet floors, material on floors, etc.?) | Yes No IF YES, PLEASE EXPLAIN: Click here to enter text. |
| 6. | Was the material handled in accordance with department policy?  | Yes No IF NO PLEASE EXPLAIN: Click here to enter text. |
| 7. | How often is this job done? | Click here to enter text. |
| 8. | Was the accident reported immediately?  | Yes No IF NO PLEASE EXPLAIN: Click here to enter text. |
| 9. | Who was the employee working with at the time of the accident? | Click here to enter text. |
| 10. | Has the employee had previous material handling accidents?  | Yes No UnknownIF YES, PLEASE EXPLAIN: Click here to enter text. |

**Slips, Trips or Falls** **NOT APPLICABLE**

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| 1. | What was the condition of the walking surface? (i.e., damaged, worn, wet, icy, cluttered) | Click here to enter text. |
| 2. | Was hazardous condition reported prior to the accident? | Yes No  |
| 3. | How long had the condition existed? | Click here to enter text. |
| 4. | Was the hazardous condition corrected?If no, please explain why?If yes, please explain When and How? | Yes No PLEASE PROVIDE DETAIL: Click here to enter text. |
| 5. | Was the lighting adequate? | Yes No  |
| 6. | Was the employee wearing appropriate footwear? | Yes No  |
| 7. | Was the employee carrying / pulling anything? | Yes No  |
| 8 | Have similar accidents occurred in this location prior to this accident? | Yes No  |

**COMPLETED BY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**JOINT LOSS MANAGEMENT COMMITTEE COMMENTS**

(Section to be completed monthly by the Joint Loss Management Committee)

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| --- | --- | --- |
| 1. | Committee’s opinion if accident was preventable? (If no, please explain) | Yes No IF NO, PLEASE EXPLAIN:Click here to enter text. |
| 2. | Does the JLMC agree with the corrective action to prevent recurrence? If not, what corrective action should be taken? | Yes No IF NO, PLEASE EXPLAIN:Click here to enter text. |
| 3. | Was the corrective action timely? (If no, please explain) | Yes No IF NO, PLEASE EXPLAIN:Click here to enter text. |
| 4. | Does the unsafe act or condition which led to this investigation exist elsewhere on the premises? If yes, what is being done to prevent a similar accident? | Yes No IF YES, PLEASE EXPLAIN:Click here to enter text. |

**ACCIDENT REVIEW COMMITTEE CHAIR SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Comment

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| --- |
| Click here to enter text. |