**Southeastern Louisiana University Incident/Accident Form**

**Worker’s Compensation Claims**

#  (PLEASE TYPE OR PRINT)

ACCIDENT DATE AND TIME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REPORTING DATE AND TIME

EMPLOYEE NAME (LAST, FIRST)

EMPLOYEE’S W#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYEE’S ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYEE’S HOME PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYEE’S WORK PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYEE’S DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER \_\_\_\_\_M \_\_\_\_\_\_F

RACE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NUMBER OF CHILDREN UNDER THE AGE OF 18\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

JOB TITLE \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ BUDGET UNIT NAME/NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IMMEDIATE SUPERVISOR

NAME OF PERSON ACCIDENT REPORTED TO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE EMPLOYER KNEW OF INJURY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NORMAL STARTING TIMEDAY OF ACCIDENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE LOSS TIME BEGAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IF EMPLOYEE BACK TO WORK GIVE DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXACT LOCATION WHERE ACCIDENT OCCURRED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESCRIBE IN DETAIL HOW INCIDENT/ACCIDENT OCCURRED *(USE ADDITIONAL SHEET IF NECESSARY)*

PARISH WHERE OCCURRED PARISH OF DOMICILE

PARTS OF BODY AFFECTED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WAS MEDICAL TREATMENT REQUIRED Y N

IF YES, LIST ATTENDING PHYSICAN’S NAME AND ADDRESSS

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 NAME (S) AND PHONE NUMBER(S) OF ALL WITNESSES

NAME AND TITLE OF PERSON COMPLETING THIS SECTION OF REPORT

14. SIGNATURE 15. DATE

MANAGEMENT SECTION

 (TO BE COMPLETED BY SUPERVISOR)

NAME OF PERSON COMPLETING THIS SECTION OF REPORT

POSITION/TITLE

 IS THE PERSON COMPLETING REPORT TRAINED IN ACCIDENT INVESTIGATION \_\_\_\_\_\_ Y \_\_\_\_\_\_ N

WAS EQUIPMENT INVOLVED \_\_\_\_\_\_Y \_\_\_\_\_\_N (If no, skip to question 20)

A. TYPE OF EQUIPMENT

B. IS THERE A JSA FOR EQUIPMENT \_\_\_\_\_\_Y \_\_\_\_\_\_ N C. DATE LAST JSO PERFORMED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 HAVE SIMILAR ACCIDENT/INCIDENTS OCCURRED \_\_\_\_\_\_Y \_\_\_\_\_\_N

 DID INCIDENT INVOLVE SAME INDIVIDUAL \_\_\_\_\_Y \_\_\_\_\_\_N

SAME LOCATION \_\_\_\_\_\_Y \_\_\_\_\_\_N

WAS THE SCENE VISITED DURING THE INVESTIGATION \_\_\_\_\_\_Y \_\_\_\_\_\_N

A. DATE & TIME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ B. ARE PICTURES AVAILABLE \_\_\_\_\_\_Y \_\_\_\_\_\_N

C. IF NO, REASON FOR NOT VISITING

**ROOT CAUSE ANALYSIS**

|  |
| --- |
| *UNSAFE ACT (****PRIMAR****Y):* *[ ] Failure to comply with policies/procedures* *[ ] Failure to use appropriate equipment/technique* *[ ] Inattentiveness* *[ ] Inadequate/lack of JSA/standards* *[ ] Incomplete or no policies/procedures* *[ ] Inadequate training on policies/procedures* *[ ] Inadequate adherence of policies/procedures**Other (specify)* *Detailed explanation of checked box*  |
| *WHY WAS ACT COMMITTED:* |
| *UNSAFE CONDITION* ***(PRIMARY****):* *[ ] Inappropriate equip/tool* *[ ] Inadequate maintenance* *[ ] Inadequate training* *[ ] Wet surface* *[ ] Worn/broken/defective building components* *[ ] Broken equipment* *[ ] Inadequate guard* *[ ] Electrical hazard* *[ ] Fire Hazard**Other (specify)* *Detailed explanation of checked box*  |
| *WHY DID CONDITION EXIST:* |
| *CONTRIBUTORY FACTORS (IF ANY):* |
| *IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:* |
| *LONG RANGE ACTION TO BE TAKEN:* |
| *WHAT ADDITIONAL ASSISTANCE IS NEEDED TO PREVENT RECURRENCE:* |

##### ***KEEP COPIES OF ALL COMPLETED FORMS ON FILE AT THE LOCATION***

***WHERE INCIDENT/ACCIDENT OCCURREDAND MAIL THE ORIGIANLS TO THE HUMAN RESOURCES OFFCICE, SLU 10799***