ACCIDENT ANALYSIS FORM

(for internal use only)

District Office: _____ **Date of Report:** _____

Jobsite / Location: _____ **Date and time of Accident:** _____

Employee Name: _____ **Position:** _____

Supervisor: _____ **Date notified of accident:** _____

Injury: Yes ___ No ___ If Yes, Body Part(s) & Diagnosis if known: _____
Property Damage: Yes ____ No____ If Yes, Describe Damage(s): _____

Description of task performed leading to accident:

_____

_____

Root cause of accident:

_____

_____

_____

Use back of form for additional space

Unsafe acts	**Check box**	**Unsafe Condition**	**Check box**
Improper work/task technique		Poor workstation design	
Safety rule violation		Unsafe operation method	
Improper PPE or PPE not used		Improper maintenance	
Operating without authority		Lack of direct supervision	
Failure to warn or secure		Time restraints or fatigue from long work hours	
Improper speed or unsafe operation		Lack of experience or training	
By-passing safety devices		Insufficient knowledge of job	
Protective equipment not in use (Guards, etc.)		Site conditions (weather, housekeeping, etc.)	
Improper loading or placement		Excessive noise	
Improper lifting		Inadequate guarding of hazards	
Servicing machinery or tool in motion		Defective tools/equipment	
Horse play		Insufficient lighting	
Drug or alcohol use		Other trade or contractor hazards	

Witness Name (s): _____Witness Signatures: _____
Statement_____

_____

_____

Use back of form for additional space

This accident has been reviewed with:
Employee(s): _____ Date: _____

District Manager: _____ Date: _____

Field Safety Manager: _____ Date: _____

Corrective actions identified and implemented ___Yes ___ No Re-Training Completed: ___Yes ___ No

Manager Responsible for Corrective Action Plan Implementation: _____