BASTROP COUNTY Accident/Incident Report

The Accident Report must be submitted to the Human Resources Department within 24 hours.
Send the Original to Human Resources in person or Inner Office Mail

This incident is an ☐ **Injury** ☐ **Illness** ☐ **Near-miss**

Date of Ocurrance (M M D D Y Y)	Time of Occurance (HR) ☐ AM ☐ PM	Date Reported (M M D D Y Y)	Reported to

Department	Department Head	Department Phone Number

1. Name of Employee (Last Name, Fisrt Name MI)	2. Job Title

3. Shift	4. Sex ☐ M ☐ F	5. Age	6. Social Security Number	7. Employee ID#

8. Employee was working ☐ Alone ☐ with Fellow Workers ☐ Other:

9. Employment Category ☐ Regular full-time ☐ Regular part-time ☐ Temporary ☐ Seasonal ☐ Non-Employee

10. Experience in Occupation at Time of Incident ☐ Less than 1 month ☐ 1-5 months ☐ 6months to 1 year ☐ 1-4 years ☐ 5years or more

11. Name of Physician	Address of Physician	Phone# of Physician

12. Name and Address of Hospital

13. Address location of Incident ☐ Indoor ☐ Outdoor

14. Phase of Employee's Work Day at Time of Injury

☐ Druring break period ☐ Entering/Leaving the building ☐ Performing Work Duties ☐ Working Ovetime ☐ During Lunch period

☐ other (describe)

15. Employee's Supervisor at time of Accident? Witnessed Accident? ☐ Yes ☐ No

16. Probable Re-occurance ☐ Frequent ☐ Occasional ☐ Rare

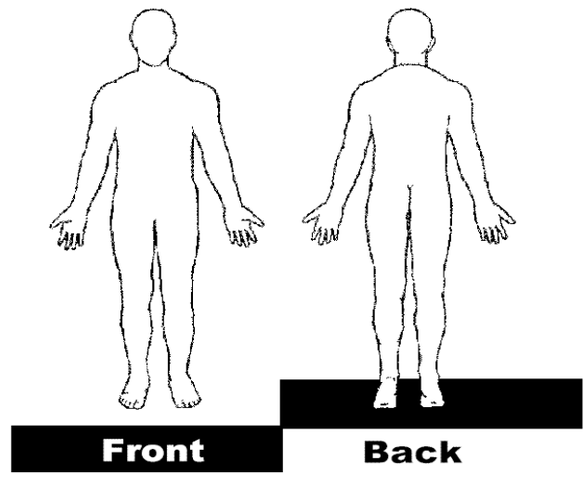
17. Loss Serverity Potential ☐ Major ☐ Serious ☐ Minor

18 PART of BODY INJURED or A Injury

☐ Right Side	☐ Left Side		
☐ Eye	☐ Neck	☐ Shoulder	☐ Thigh
☐ Nose	☐ Upper Back	☐ Upper Arm	☐ Knee
☐ Mouth	☐ Lower Back	☐ Elbow	☐ Ankle
☐ Jaw	☐ Spine	☐ Forearm	☐ Foot
☐ Throat	☐ Chest	☐ Wrist	☐ Toe
☐ Ear	☐ Abdomen	☐ Hand	☐ Toe Nail
☐ Head/Scalp	☐ Pelvis	☐ Finger	☐ Skin
	☐ Hip	☐ Finger Nail	

☐ *Other(describe)*

Mark Area Injured



19.Nature of Injury or illness

☐ Puncture	☐ Bruise,Contusion	☐ Skin Disorder	☐ Amputation	☐ Muscle Sprain	☐ Cumalative Trauma Disorder
☐ Laceration	☐ Dislocation	☐ Burn	☐ Insect/Animal Bite	☐ Muscle Strain	☐ Irritation
☐ Fracture	☐ Abrasion	☐ Respiratory	☐ Foreign Body	☐ Hernia	☐ Infection

☐ *Other(describe)*

20. MEDICAL ATTENTION

First Aid was provided by: Sent to ☐ Doctor ☐ Hospital

21. SEVERITY

☐ Fisrt Aid ☐ Medical Treatment ☐ Lost Work Days ☐ Fatality ☐ *Other(specify)*

Supervisor	Print Name	Department
	Signature	Date

22. WHAT CONDITION of TOOLS, EQUIPMENT, or WORK AREA CONTRIBUTED to the ACCIDENT?

- ☐ Close Clearance/Congestion
- ☐ Floors/Work Surfaces
- ☐ Inadequate Housekeeping
- ☐ Defective Tools/Equipment/Vehicle
- ☐ Hazardous Placement
- ☐ Inadequate Ventilation
- ☐ Equipment Failure
- ☐ Illumination
- ☐ Inadequate Warning System
- ☐ Improper Motivation Design
- ☐ Inadequate Guards/Barriers
- ☐ Inadequate/Improper PPE
- ☐ *Other(specify)* _____

23. WHAT CAUSED or INFLUENCED SUBSTANDARD CONDITIONS

- ☐ Abuse or Misuse
- ☐ Inadequate Supervision
- ☐ Inadequate Purhcasing
- ☐ Inadequate Engineering
- ☐ Inadequate Maintenance
- ☐ Improper Motivation
- ☐ Inadequate Tools/Equipment
- ☐ Wear and Tear
- ☐ Lack of Knowledge or Training
- ☐ Inadequate Capacity
- ☐ Improper Work Surfaces
- ☐ Lack of Skill
- ☐ *Other(specify)* _____

23. WHAT CAUSED or INFLUENCED SUBSTANDARD CONDITIONS

- ☐ Failure to make Secure
- ☐ Used Defective Equipment
- ☐ Horseplay/Distractive Action
- ☐ Inadequate/Improper PPE use
- ☐ Nullified Safety/Control Devices
- ☐ Improper Lifting
- ☐ Operating Procedure Deviation
- ☐ Operating at Improper Speed
- ☐ Used Equipment Improperly
- ☐ Unauthorized Actions
- ☐ Used Wrong Tool/Equipment
- ☐ Running/Rushing/Acting in Haste
- ☐ Improper Loading
- ☐ Improper Position
- ☐ Servicing/Operating Equipment
- ☐ Under the Influence of Drugs/Alcohol
- ☐ Improper Technique
- ☐ Failure to Warn/Signal
- ☐ *Other(specify)* _____

24. PREVENTATIVE MEASURES (What corrective actions have been taken or are planned to prevent recurrence)

- ☐ Improve Enforcement
- ☐ Repair/Replace Equipment
- ☐ Task Analysis to be Completed
- ☐ Task Analysis/Procedure Revision
- ☐ Improve Storage/Arrangement
- ☐ Eliminate Congestion
- ☐ Install/Revise Guards/Devices
- ☐ Improve/Change Work Methos
- ☐ Identify/Improve PPE
- ☐ Improve Illumination
- ☐ Re-Instruction of Employee
- ☐ Improve Clean-Up Procedures
- ☐ Improve Design/Construction
- ☐ Corrective Counseling
- ☐ Use Other Materials/Supplies
- ☐ Job Reassignment/Rotation of Employee
- ☐ Mandatory Pre-Job Instructions
- ☐ Improve Ventillation
- ☐ *Other(specify)* _____

25. WITNESS LIST Identify any witnesses to the incident. Have each of them complete a witness statement form.

1. Full Name	Statement ☐ Yes ☐ No
2. Full Name	Statement ☐ Yes ☐ No
3. Full Name	Statement ☐ Yes ☐ No
4. Full Name	Statement ☐ Yes ☐ No

26. SUPPLEMENTAL DATA/MEDIA

Item 1	Included ☐ Yes ☐ No
Item 2	Included ☐ Yes ☐ No
Item 3	Included ☐ Yes ☐ No
Item 4	Included ☐ Yes ☐ No

Supervisor	Print Name	Department
	Signature	Date

Please PRINT LEGIBLY!

SUPERVISOR'S DESCRIPTION of INCIDENT

Please fully describe the incident sequence from the start to finish. End with the nature and extent of the injury/illness.

CORRECTIVE ACTION TAKEN/RECOMMENDED

Action Item	Person Responsible

Target Date	Completed Date

Action Item	Person Responsible

Target Date	Completed Date

Action Item	Person Responsible

Target Date	Completed Date

Action Item	Person Responsible

Target Date	Completed Date

Supervisor	Print Name	Department
	Signature	Date
DEPARTMENT Head Review	Print Name	Department
	Signature	Date
ELECTED OFFICIAL Review	Print Name	Department
	Signature	Date

BASTROP COUNTY Accident/Incident Report

EMPLOYEE STATEMENT

Please PRINT LEGIBLY!

EMPLOYEE INFORMATION

Last Name	First Name	Middle Name / Initial

Home Address:	Home Phone Number:
Department / Division	Work Phone Number:

ACCIDENT/INCIDENT DETAILS

Date of Occurrence (M M D D Y Y)	Time of Occurrence ____ hr/min ☐ AM ☐ PM	Loss Occurred ☐ Indoors ☐ Outdoors	On Bastrop County Premises ☐ Yes ☐ No
Date Reported (M M D D Y Y)	Time Reported ____ hr/min ☐ AM ☐ PM	Please name who you reported the loss and their title:	

Specific Location of Incident:

Please fully describe the incident sequence from the start to finish. End with the nature and extent of the injury/illness.

Identify the personal protective equipment in use at the time of the loss, or check here ☐ for none.

Did you observe anything unusual prior to or during the loss (sight, sound, odor, etc.)?

☐ **I certify that the information provided in this report is true.**

☐ **I understand that any falsification of information regarding an on the job injury may result in disciplinary action.**

☐ **I hereby authorize the release of all medical records relating to the injury to my employer and insurance provider.**

Employee	Print Name	Department
	Signature	Date
Supervisor Review	Print Name	Department
	Signature	Date

BASTROP COUNTY Accident/Incident Report

WITNESS STATEMENT

Please PRINT LEGIBLY!

WITNESS STATEMENT(1)

Last Name	First Name	Middle Name / Initial

Home Address:	Home Phone Number:

Employer/Department/Division	Work Phone Number:

ACCIDENT/INCIDENT DETAILS

Date of Occurrence (M M D D Y Y)	Time of Occurrence (hr/min)	AM / PM	Date Reported (M M D D Y Y)	Time Reported (hr/min)	AM / PM

Please fully describe the incident sequence from the start to finish.

Witness	Print Name	Employer/Department
	Signature	Date
Supervisor Review	Print Name	Department
	Signature	Date