

City of Klamath Falls

SUPERVISOR'S ACCIDENT or "NEAR-MISS" INVESTIGATION REPORT

(All incidents must be reported *regardless* of whether the employee received medical attention)

WHAT type of incident was it? Accident Employee Injury Near-Miss Exposure

SECTION 1 WHO and When

Name: _____ Date Reported: _____

Department/Division: _____ Job Title: _____

Employment Category: Full-time Part-Time Temporary Volunteer

Normal Shift: From _____ a.m. p.m. To _____ a.m. p.m.

Status at Time of Accident: Enter or leaving Work During Meal Period During Rest Period
 Performing Work Duties Working Overtime Other _____

Witnesses:

Time of Incident _____ a.m. p.m. Day of the Week _____

SECTION 2 WHAT and Where

WHAT happened before, during and after the incident?? (This section must be completed in detail; add additional pages if necessary)

Employee was working: Alone With a crew or fellow worker Other _____

Supervision at time of accident: Directly Supervised Not Supervised
 Indirectly Supervised Supervision not feasible

Has this type of incident occurred in the past within the division? YES NO

If yes, please explain:

Location description _____

Address _____

SECTION 3 VEHICLE/MACHINE/EQUIPMENT

Was there Damage? YES NO

If yes, complete this section (Photos must be attached). If no, skip to Section 4.

Make: _____ Model: _____ Year: _____

Plate #: _____ City Id: _____

Did you contact law enforcement? YES NO If yes, was an officer dispatched? YES NO

If yes, what was the name of the officer? _____

What was the CAD number or report number? _____

Did the accident involve another Driver? YES NO If yes, did you exchange information and complete the yellow accident card? YES NO.

Explain the type of damage (Insurance claims must be filed with the appropriate department)

Did you take the vehicle to the Streets Division for inspection by a Fleet Mechanic? YES NO

SECTION 4 PROPERTY

Was there Damage? YES NO If yes, complete this section (Photos must be attached). If no, skip to Section 5.

Property Description: _____

Property address/location: _____

City owned property? YES NO If no, did you contact the owner? YES NO

Was the incident reported? YES NO If yes, who was it reported to? _____

Explain the type of damage (Insurance claims must be filed with the appropriate department)

SECTION 5 INJURY

Was there an injury? YES NO If yes, complete this section. If no, skip to section 6.

Area Injured: Face/head Leg(s) Hand(s)/finger(s) Skin Eye(s) Toe(s)/foot
 Arm(s) Back/Torso Lungs Other _____

Type of Injury: Scrape/Cut Strain/sprain Burn Fracture Bruise
 Foreign body Death* Other _____

Type of Care:

Was First Aid Given? YES NO Was Medical Treatment Offered? YES NO
Sent for Medical Treatment? YES NO Overnight in hospital?* YES NO
801 Form Completed? YES NO

*(Fatalities must be reported within 8 hours to OSHA (800) 922-2689. Overnight hospitalizations must be reported to an OSHA field office within 24 hours of employer notification Medford 541-776-6030. If OSHA needs to be notified, contact the Risk Manager who will contact OSHA.

SECTION 6 FACTORS

What contributed to the incident? Please check all that apply.

Hazard

- Not Recognized/Identified
- Identified, but not addressed
- Inadequate repair

Other

- Weather/Temperature
- Extended Work Hours
- Physical Overexertion
- Work in Elevated Area
- Chemical Use
- Biological Agent
- Radiation
- Electricity
- Mechanical
- Animals

Facilities/Equipment

- PPE (See Section 7)
- Faulty Equipment
- Poor/ Inadequate Maintenance
- Inappropriate Use
- Missing Guards
- Obsolete/Antiquated
- Inadequate Design
- Ergonomic Factors
- Equipment Failure
- Trip Hazard
- Slip Hazard
- Struck By

Training & Certification

- Insufficient Training
- Circumstances Not Covered
- Ineffective Training
- Worker Not Authorized
- Outdated Training

Communication

- Breakdown in verbal communication
- Breakdown in written communication
- Confusion after communication

Work Procedures

- None Developed
- Not Followed
- Partially Followed
- Not Understood
- Not Appropriate
- Not Communicated

SECTION 7

PPE Requirements:

	Required	Used	Type
Eye Protection	<input type="checkbox"/>	<input type="checkbox"/>	
Face Protection	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Protection	<input type="checkbox"/>	<input type="checkbox"/>	
Skin/Gloves	<input type="checkbox"/>	<input type="checkbox"/>	
Foot	<input type="checkbox"/>	<input type="checkbox"/>	
Safety Vest	<input type="checkbox"/>	<input type="checkbox"/>	
Tire Chains	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	

SECTION 8

PREVENTION: How can a similar incident be prevented?

Were measures taken to prevent reoccurrences? YES NO Not applicable

If yes, what actions were taken, when and by whom?

OR Corrective action is scheduled for _____

SECTION 9

ACKNOWLEDGEMENTS

Employee Signature

Date

Supervisor Signature

Date

Department Director Signature

Date

Supervisor provides copy to Department Director
Original to Human Resources; If required, HR provides copy to Central Safety Committee, Streets Division,
and Legal.