

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
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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 \_\_\_\_\_

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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 \_\_\_\_\_

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**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)

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

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**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)

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**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.

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**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

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**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"/>	_____
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"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

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**SECTION 8**

PREVENTION: How can a similar incident be prevented?

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Were measures taken to prevent reoccurrences?  YES  NO  Not applicable

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

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OR  Corrective action is scheduled for \_\_\_\_\_

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**SECTION 9**

**ACKNOWLEDGEMENTS**

\_\_\_\_\_  
**Employee Signature** \_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Supervisor Signature** \_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Department Director Signature** \_\_\_\_\_  
**Date**

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