



PLUMAS COUNTY

Accident, Injury, and Illness Investigation Form

General Information:

Department:	Today's Date:			
Date of Incident/Injury:	Date Reported:	Time of Incident/Injury:		
Location of Accident/Injury/Incident:				
Name of Injured Employee:				
SSN:	Sex: Male	Female	Home Phone #:	
Home Address:	Employees Usual Occupation:			
	Length of Employment:			
	Job Title at Time of Incident:			
	Time in Occupation at Time of Incident:			
<u>Phase of Employee's Workday at time of Accident or Incident (Circle One)</u>				
Break	Entering or Leaving Facility	Meal	Performing Work	Other
<u>Severity of Injury/Illness/Incident (Circle Applicable)</u>				
Fatality	Lost Workdays-Days Away from Work		Lost Workdays-Modified Work	
Medical Treatment	First Aid Only		Near Miss with Vehicle	
Any Damage to County Property			Other	
Damage to County Property over \$500				
<u>Other Workers Involved or Witness to Accident or Incident:</u>				

Injury Information:

Accident Type: (what caused physical harm)	<input type="checkbox"/> Struck against <input type="checkbox"/> Struck by <input type="checkbox"/> Fall from height <input type="checkbox"/> Fall on same level <input type="checkbox"/> Overexertion (strain) <input type="checkbox"/> Caught in	<input type="checkbox"/> Caught on <input type="checkbox"/> Caught between <input type="checkbox"/> Contact with <ul style="list-style-type: none"><input type="checkbox"/> Electricity<input type="checkbox"/> Heat<input type="checkbox"/> Cold	<input type="checkbox"/> Contact with <ul style="list-style-type: none"><input type="checkbox"/> Radiation<input type="checkbox"/> Caustics<input type="checkbox"/> Noise<input type="checkbox"/> Toxic <input type="checkbox"/> Other
Nature of Injury:	<input type="checkbox"/> Foreign particle in eye <input type="checkbox"/> Burn <input type="checkbox"/> Puncture <input type="checkbox"/> Insect bite <input type="checkbox"/> Dermatitis	<input type="checkbox"/> Cut or laceration <input type="checkbox"/> Amputation <input type="checkbox"/> Fracture <input type="checkbox"/> Strain or sprain <input type="checkbox"/> Multiple Injuries	<input type="checkbox"/> Bruise or contusion <input type="checkbox"/> Illness <input type="checkbox"/> Repeated trauma <input type="checkbox"/> Other
Part of Body Affected:	<input type="checkbox"/> Head <input type="checkbox"/> Eyes <input type="checkbox"/> Arms <input type="checkbox"/> Hands <input type="checkbox"/> Back	<input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Fingers <input type="checkbox"/> Ankle	<input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Face <input type="checkbox"/> Neck <input type="checkbox"/> Other

Description of How Accident, Illness, or Injury Occurred: What Happened?

(Attach additional pages as necessary)

Contributing Factors:

Workplace conditions that contributed to the accident	<input type="checkbox"/> Inadequate guard or protection <input type="checkbox"/> Defective tools or equipment <input type="checkbox"/> Congestion <input type="checkbox"/> Inadequate warning system <input type="checkbox"/> Fire or explosion hazard	<input type="checkbox"/> Substandard housekeeping <input type="checkbox"/> Hazardous atmospheric conditions <input type="checkbox"/> Excessive noise <input type="checkbox"/> Radiation exposure <input type="checkbox"/> Inadequate illumination <input type="checkbox"/> Other
Unsafe work practices that contributed to the accident	<input type="checkbox"/> Operating equipment without authority <input type="checkbox"/> Failure to warn or secure <input type="checkbox"/> Operating at improper speed <input type="checkbox"/> Making safety devices inoperable <input type="checkbox"/> Using equipment improperly <input type="checkbox"/> Failure to use personal protective equipment <input type="checkbox"/> Other	<input type="checkbox"/> Improper loading or placement <input type="checkbox"/> Improper lifting <input type="checkbox"/> Taking improper position <input type="checkbox"/> Servicing equipment in motion <input type="checkbox"/> Horseplay <input type="checkbox"/> A code of safe practices violated? If so, which one.

Incidence Sequence:

List tasks being performed that led to accident and who was doing them.	

Findings:

List possible causes or actions that may have contributed to the accident or incident:	

Corrective Actions Necessary:

What corrective actions need to be taken to prevent another accident (Indicate all that apply)	<input type="checkbox"/> Operator training needed <input type="checkbox"/> Provide better warning <input type="checkbox"/> Operating procedures posted <input type="checkbox"/> Replacement of safety devices <input type="checkbox"/> Specific equipment instruction <input type="checkbox"/> Use of necessary personal protective equipment	<input type="checkbox"/> Loading or placement training <input type="checkbox"/> Safe lifting training <input type="checkbox"/> Lockout and tagout of energy sources <input type="checkbox"/> Training on code of safe practices <input type="checkbox"/> Disciplinary actions <input type="checkbox"/> Other
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Corrective Actions Taken:

Clarify the specific corrective actions taken, who is responsible and when will they be accomplished:	

Department Head: _____

Date: _____

Supervisor: _____

Date: _____

Safety Committee Chairman: _____

Date: _____

Date Entered into System: _____

Date: _____

INTERNAL USE ONLY!

PLUMAS COUNTY

INCIDENT/HAZARD REPORT

SECTION A	<input type="checkbox"/> INJURY INCIDENT	<input type="checkbox"/> INCIDENT/NEAR MISS	<input type="checkbox"/> HAZARD
DATE & TIME OF INCIDENT:	LOCATION:	DATE REPORTED:	
REPORTED TO:	REPORTED BY: (Optional)	DEPARTMENT:	
SECTION B	DESCRIPTION OF INCIDENT - INJURY, INCIDENT/NEAR MISS, HAZARD		
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SECTION C	CAUSES		
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>			
SECTION D	SUGGESTED CORRECTIONS		
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INVESTIGATED BY:	TITLE:		DATE:
SECTION E	CORRECTIVE ACTION		DATE
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>			
Department Safety Representative Signature:	Date:	Department Head Signature:	Date:
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