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RANCHO SANTIAGO COMMUNITY COLLEGE DISTRICT

Employee/Volunteer Accident Investigation Report

This is a CONFIDENTIAL REPORT for use by Rancho Santiago Community College District and its attorneys. No copies of this report shall be furnished to anyone including employees or parents without permission from the office of Risk Management.

This report must be completed within 24 hours of an accident involving an injury to an employee/volunteer. Send completed reports to Risk Management and keep one copy of this investigation at your location.

Part I To Be Completed By Injured/Ill Employee/Volunteer

Employee ☐ Volunteer ☐ Student Employee ☐

Name of Injured Person: _____ Home Telephone: _____

Home Address: _____ City: _____ Zip: _____

Date of Birth: _____ Employee #: _____ Work Location: Campus _____

Department: _____ Job Title or Occupation: _____

Average Hours worked per week: _____ Average hours worked per day: M ___ T ___ W ___ Th ___ Fr ___ Sa ___ Su ___

Employee's Supervisor: _____ Department Phone #: _____

WHEN AND WHERE DID THIS HAPPEN?

Date of Injury: _____ Time of Injury: _____ Date Reported: _____ Time Reported: _____

Location of Injury (Campus) _____

Exact location of injury (Building, Room #) _____

(If injury happened off-site indicate location, address, city and zip:) _____

HOW DID THE INJURY OCCUR?

Describe what happened and what you were doing just prior to the injury. What tools or equipment were involved?

_____

_____

_____

WHAT INJURIES RESULTED?

Type of injuries and body part(s) injured. Example: "Cut left pinky finger and hurt lower back".

_____

_____

_____

Employee Signature **Date**

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Part II To Be Completed By Supervisor (Within 24 Hours Of Knowledge Of Incident)

DID ANYONE SEE THE INJURY HAPPEN? Attach statements of each witness.

Names: _____

DID SOMEONE ELSE CAUSE THE INJURY?

Name of Witness: _____ Home Telephone: _____

Home Address: _____ City: _____ Zip: _____

MEDICAL TREATMENT PROVIDED BY:

Health Center ☐ Campus Safety ☐ EMT ☐ Treatment Declined ☐ No Treatment ☐ Other _____

Describe type of treatment? _____

Did the injured party go to a hospital or clinic? Yes ☐ No ☐ if so, name of medical facility: _____

Was employee hospitalized overnight? Yes ☐ No ☐

ACCIDENT INVESTIGATION:

What happened?

_____

_____

What was the cause of the injury? Please check all that apply. Attach photos if available.

Unsafe Condition

- ☐ Equipment was improperly guarded.
- ☐ Safety device was inoperative.
- ☐ Equipment was defective.
- ☐ Hazardous arrangement or procedure.
- ☐ Improper lighting.
- ☐ Improper ventilation.
- ☐ Unsafe dress or apparel.
- ☐ Poor housekeeping
- ☐ Other (please explain)

Unsafe Act

- ☐ Operating equipment without authority
- ☐ Operating equipment at unsafe speeds.
- ☐ Making safety devices inoperative.
- ☐ Taking unsafe position or posture.
- ☐ Handling material incorrectly.
- ☐ Workiing on moving or dangerous equipment.
- ☐ Failure to use personal protective equipment.
- ☐ Distracting, teasing, or general horseplay.
- ☐ Failure to follow rules or instructions.

_____

What have you done to prevent recurrence?

Corrective action taken

- ☐ Repaired or replaced equipment. Date _____
- ☐ Provided personal protective equipment.
- ☐ Wrote safety procedures.
- ☐ Revised existing written safety procedures.
- ☐ Cleaned area.
- ☐ Provided personal re-instruction/training.
- ☐ Disciplined employee.
- ☐ Initiated a work order
- ☐ Other (please explain)

_____

Supervisor's Signature: _____ **Date:** _____