

**ADAMS COUNTY BOCES MEMBER
ACCIDENT/INCIDENT INVESTIGATION REPORT**

This form must be completed within 24 hours of the incident by the employee's Supervisor.

EMPLOYEE INFORMATION			
Employee's Name:	Employee ID:	Employee's Phone #:	
WORK-SITE INFORMATION			
School Name:	Work-site Address:	Department/ Room:	Principal Name & Phone:
Job Title:	Regular Job Duties:		
ACCIDENT OR INCIDENT INFORMATION			
Date of Accident/Incident?	Time of Accident/Incident: 00:00 <input type="checkbox"/> AM <input type="checkbox"/> PM	Shift Begin Time: 00:00 <input type="checkbox"/> AM <input type="checkbox"/> PM	Shift End Time: 00:00 <input type="checkbox"/> AM <input type="checkbox"/> PM
Scheduled Work Days (circle): S,M,T,W,Th,F, Sat.	Day of Week Accident occurred:		
Date Reported to District:	Date Reported to Supervisor:	Signs of Drug or Alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fatality? <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe Accident/Incident: (Include Specific Details, use additional sheet if necessary)			
Safety Equipment Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Safety Equipment Used? <input type="checkbox"/> Yes <input type="checkbox"/> No	Unsafe Act? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a Safety Committee? <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe Unsafe Act:			
Machine Part Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Machine Part Defective? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	3 rd Party Responsible? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	First Aid Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No
Machine Involved? (note: make/model/model #):			
Witness 1 Name: Phone #: Address:		Witness 2 Name: Phone #: Address:	
Check Cause(s) that contributed to incident/Accident:			
<input type="checkbox"/> A. Design of equipment or Facility	<input type="checkbox"/> J. Incorrect or lack of PPE		
<input type="checkbox"/> B. Job instruction inadequate	<input type="checkbox"/> K. Inadequate training		
<input type="checkbox"/> C. Rules & Procedures ignored	<input type="checkbox"/> L. Chemical exposure		
<input type="checkbox"/> D. Ergonomics relating to work	<input type="checkbox"/> M. Improper vehicle operation		
<input type="checkbox"/> E. Incorrect or misuse of tools	<input type="checkbox"/> N. Environmental Factors		
<input type="checkbox"/> F. Missing/misused Guarding	<input type="checkbox"/> O. Animal, reptile, insect		
<input type="checkbox"/> G. Improper equip .operation	<input type="checkbox"/> P. Inattention to detail		
<input type="checkbox"/> H. Poor Housekeeping	<input type="checkbox"/> Q. Actions of others		
<input type="checkbox"/> I. Lack of maint. or inspection	<input type="checkbox"/> R. Other		
If other, please note:			
CORRECTIVE ACTION INFORMATION			
Is Corrective Action Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes , Describe Corrective Action:	If No , Describe Reasoning:	
	Corrective Action Target Completion Date:		
Preparer's Name:	Phone #:	Date:	