

PHOENIX-TALENT SCHOOLS

SUPERVISOR'S ACCIDENT/ILLNESS ANALYSIS (Fact-finding, Not fault-finding)

Employee: _____ Job Title: _____

Department: _____ Date of Hire: _____

Accident Location: _____ Supervisor: _____

Date of Injury: _____ Time of Injury: _____ 801 Filed? Yes No

Accident Reported to: _____ Time Reported: _____

Date Accident Reported: _____ How Reported: _____

Treatment Required: First Aid Doctor Hospital

| PART(S) OF THE BODY AFFECTED | | |
|-------------------------------------|--------------------------|--------------------------|
| Head/Neck | Left Side | Right Side |
| <input type="checkbox"/> Scalp | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ears | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Face | <input type="checkbox"/> | <input type="checkbox"/> |
| Upper Extremities | Left Side | Right Side |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Upper Arm | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Forearm | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Fingers | <input type="checkbox"/> | <input type="checkbox"/> |
| Lower Extremities | Left Side | Right Side |
| <input type="checkbox"/> Thigh | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lower Leg | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Knee | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot/Toes | <input type="checkbox"/> | <input type="checkbox"/> |
| Trunk | Left Side | Right Side |
| <input type="checkbox"/> Lower Back | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Chest | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Groin | <input type="checkbox"/> | <input type="checkbox"/> |

| NATURE OF INJURY | |
|---------------------------------------|---|
| <input type="checkbox"/> Cut | <input type="checkbox"/> Foreign Body/Sliver |
| <input type="checkbox"/> Scrape | <input type="checkbox"/> Burn |
| <input type="checkbox"/> Bruise | <input type="checkbox"/> Electric Shock |
| <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Pain in Body Part Identified at Left |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Jammed finger or toe |
| <input type="checkbox"/> Inflammation | <input type="checkbox"/> Difficulty Breathing |

Has the employee injured this part(s) of the body previously or is there any pre-existing condition that could affect injury? Yes No

Identify: _____

| CONTRIBUTING FACTORS | |
|---|---------------------------------------|
| <input type="checkbox"/> Defective Tool/Equip/Machine (Save defect. parts & pieces) | |
| <input type="checkbox"/> Equipment Inadequately Guarded | |
| <input type="checkbox"/> Proper Tools/Equipment Unavailable | |
| <input type="checkbox"/> Floor, Work Surface, or Walking surface | |
| <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Lighting |
| <input type="checkbox"/> Student Behavior | <input type="checkbox"/> Other: _____ |

| WORK BEHAVIOR AT THE TIME OF INJURY | |
|--|---|
| <i>(Please check all items that pertain)</i> | |
| <input type="checkbox"/> Lifting/Carrying | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Pushing/Pulling | <input type="checkbox"/> Bending |
| <input type="checkbox"/> Running | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Coaching | <input type="checkbox"/> Typing |
| <input type="checkbox"/> Jumping | <input type="checkbox"/> Teaching |
| <input type="checkbox"/> Operating Equipment | <input type="checkbox"/> Innocent Bystander |

If Driving: Personal Vehicle District Vehicle

Other Repetitive Motion Tasks

Stepping (Walking or Moving From One Level to Another)

Other: _____

Explain what the employee was doing just before & at the time of the accident (use sequence of events, please be specific):

.....
.....
.....

How long has the employee worked at this specific job?

Have there been near-misses or minor accidents in this same activity? Has any action been taken?

.....
.....

What does the employee think can be done to prevent recurrence?

.....
.....

Was **Personal Protective Equipment (PPE)** worn? Yes No

If not, what PPE should be worn?

- | | | |
|---|--|---|
| <input type="checkbox"/> Footwear | <input type="checkbox"/> Seat Belt | <input type="checkbox"/> Hard Hat/Head Protection |
| <input type="checkbox"/> Face Shield/Safety Glasses | <input type="checkbox"/> Apron/Coveralls/Body Protection | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Respirator | <input type="checkbox"/> Hearing Protection | |

The supervisor or principal's observations and recommended next steps:

.....
.....

PROVIDE WITNESS INFORMATION ON SEPARATE PAPER

Injured Employee's Signature: Date:

Supervisor's Signature: Date:

Principal's Signature: Date:

SAFETY COMMITTEE EVALUATION

CORRECTIVE ACTION NEEDED

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Improve Design | <input type="checkbox"/> Improve Housekeeping | <input type="checkbox"/> Safety Devices | <input type="checkbox"/> Pers. Prot. Equipment |
| <input type="checkbox"/> Repair or Replace Equip. | <input type="checkbox"/> More Direct Supervision | <input type="checkbox"/> Job Safety Analysis | <input type="checkbox"/> Maintain a Clean Area |
| <input type="checkbox"/> Training | <input type="checkbox"/> Establish Rules/Procedures | <input type="checkbox"/> Discipline (Rule Enforcement) | |

SAFETY EQUIPMENT

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Adequate | <input type="checkbox"/> Improperly Used |
| <input type="checkbox"/> Inadequate | <input type="checkbox"/> Not Available |

SAFETY RULES

- | | |
|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Adequate | <input type="checkbox"/> Not Followed |
| <input type="checkbox"/> Inadequate | |

RECOMMENDATIONS: _____