☐ Near-Miss
☐ First Aid
FILE 801, IF BOXES BELOW ARE CHECKED
☐ Medical Care
☐ Time Loss
☐ Fatal

SYSTEM CHALLENGES

Management:
Do we have?
Policy Enforcement
Hazard Recognition
Accountability
Supervisor Training
Corrective Action
Production Priority
Proper Resources
Job Safety Training
Hiring Practices
Maintenance
Adequate Staffing
Safety Observations

Employee:
Was the employee?
Following Procedure
Training
Previous Injury
Mental Ability
Physical Capacity
Equipment Use
Short Cuts
PPE Worn
Safety Attitude

Equipment:
Do we have?
Proper Tool Selection
Tool Availability
Maintenance
Visual Warnings
Guarding

Environment:
What about;
Plant Layout
Temperature
Noise
Radiation
Weather
Terrain, Lighting
Vibration, Ventilation
Ergonomics
Housekeeping
Biological, Chemical

Additional Factors
☐ Faulty Equipment
☐ Non-Employee
☐ Prior Injury
☐ Late Reporting
☐ Off-the-Job Injury

(Explain any checked boxes on separate sheet)

801 Claim form must be received by SAIF within five (5) days of your knowledge of doctor visit.

Lane Community College

OSHA Log # _____
Safety Log # _____

EMPLOYEE ACCIDENT/INCIDENT ANALYSIS

Immediate supervisor should complete this form promptly with worker.

1. Employee: Dept: Phone:
2. Date/Time of Accident: Date/Time First Reported:
   Supervisor: Dept: Phone:
3. Accident Location:
4. Describe Injury (Nature of Injury/Part of Body:
5. Describe Accident Fully (what happened and why?):
6. Describe First Aid/Medical Treatment given:
   By Whom? When?
7. Identify factors which contributed to or caused the accident (refer to list on left side of page):

Management:	**Employee:**	
Equipment:	**Environment:**	
Counter Measures/Best Practice: How do we correct areas identified in the MEEE area above? Who will make changes and when will the changes be completed? Use other side if needed. Consider immediate and long-term corrective actions.	**Who?**	**By When?**

8. List witnesses & phone numbers: _____ Phone: _____
9. Treating physician, if known: _____ Phone: _____

Completed by: _____ Title: _____

Employee Signature: _____ Date/Time: _____

Supervisor Signature: _____ Date/Time: _____

Copies to: Human Resources