

Bee County, Texas  
Department

- Injury
- Incident
- Equipment/Property Damage
- Close Call / Near Hit

### Incident Reporting and Investigation Form

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Fill Out All Blocks. Be as specific as possible and include drawings, photos, additional narrative, as needed.

Building:

CP:

#### SUPERVISOR CONTACT INFORMATION

Reporting Supervisor / Investigator Name:		Title:	Directorate / Dept:	Ext:	Mailstop:
Date of Incident: (mo/day/yr)	Time of Incident: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Time of Report: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Date of Report: (mo/day/yr)		

Contractor involved? If yes, name and contact information:

#### INJURED PARTY

If no injury, check box and skip this section. <input type="checkbox"/> No injury	Injured Party's Name & Title:	Injured Party's Contact Information:			
<b>Nature of Injury/Illness:</b>	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Heat Related Illness	<b>Treatment:</b>	<b>Name &amp; Address of Treating Dr. / Facility</b>	
<input type="checkbox"/> Strain/Sprain	<input type="checkbox"/> Internal	<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> First-Aid		
<input type="checkbox"/> Fracture	<input type="checkbox"/> Burn/Scald		<input type="checkbox"/> E. R.		
<input type="checkbox"/> Laceration/Cut	<input type="checkbox"/> Foreign Body		<input type="checkbox"/> Dr.'s Office	<b>Remarks:</b>	
<input type="checkbox"/> Bruising	<input type="checkbox"/> Chemical Reaction		<input type="checkbox"/> Hospital Stay		
<input type="checkbox"/> Scratch/Abrasion	<input type="checkbox"/> Allergic Reaction	<b>Body Part Injured(s):</b>			
<input type="checkbox"/> Amputation	<input type="checkbox"/> Concussion				

#### WITNESSES AND/OR WITNESS STATEMENT

Witnesses (name and contact information)	Witness statement attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
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#### PROPERTY DAMAGE

List property / material damaged (use control numbers if available):	Nature of damage:
Object / substance inflicting damage:	Approximate cost:

#### THE INCIDENT (Use Additional Paper as Needed, Reference Below and Attach)

**Describe what happened.** (Investigate scene of incident or conditions. Describe who was involved, when and where the incident happened, what happened, and how.)

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Why did it happen? (Root Cause Analysis) (What was the root cause of the incident, i.e., actually caused the illness, injury, or incident?)		
Unsafe Acts	Unsafe Conditions	Management System Deficiencies
<input type="checkbox"/> Improper Work Technique	<input type="checkbox"/> Poor Workstation Design or Layout	<input type="checkbox"/> Lack of Written Procedures or Safety Rules
<input type="checkbox"/> Improper PPE, Not Used or Used Incorrectly	<input type="checkbox"/> Fire or Explosion Hazard	<input type="checkbox"/> Safety Rules Not Enforced
<input type="checkbox"/> Safety Rule Violation	<input type="checkbox"/> Congested Work Area	<input type="checkbox"/> Hazards Not Identified
<input type="checkbox"/> Operating Without Authorization	<input type="checkbox"/> Hazardous Substances	<input type="checkbox"/> PPE Unavailable
<input type="checkbox"/> Failure to Warn or Secure	<input type="checkbox"/> Inadequate Ventilation	<input type="checkbox"/> Insufficient Worker Training
<input type="checkbox"/> Operating at Improper Speeds	<input type="checkbox"/> Improper Material Storage	<input type="checkbox"/> Insufficient Supervisor Training
<input type="checkbox"/> By-Passing Safety Devices	<input type="checkbox"/> Improper Tool or Equipment	<input type="checkbox"/> Improper Maintenance
<input type="checkbox"/> Guards Not Used	<input type="checkbox"/> Insufficient Job Knowledge	<input type="checkbox"/> Inadequate Supervision
<input type="checkbox"/> Improper Loading or Placement	<input type="checkbox"/> Slippery Conditions	<input type="checkbox"/> Insufficient Job Planning
<input type="checkbox"/> Improper Lifting	<input type="checkbox"/> Poor Housekeeping	<input type="checkbox"/> Inadequate Hiring Practices
<input type="checkbox"/> Servicing or Adjusting Machinery in Motion	<input type="checkbox"/> Excessive Noise	<input type="checkbox"/> Poor Process Design
<input type="checkbox"/> Horseplay	<input type="checkbox"/> Inadequate Guarding of Hazards	<input type="checkbox"/> Inadequate Workplace Inspections
<input type="checkbox"/> Drug or Alcohol Use	<input type="checkbox"/> Defective Tools/Equipment	<input type="checkbox"/> Inadequate Equipment
<input type="checkbox"/> Unsafe Act(s) of Others	<input type="checkbox"/> Insufficient Lighting	<input type="checkbox"/> Unsafe Design or Construction
<input type="checkbox"/> Unnecessary Haste	<input type="checkbox"/> Inadequate Fall Protection	<input type="checkbox"/> Unrealistic Scheduling
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

**List immediate actions taken and results.**

  
  
  
  

**What should be done to prevent a recurrence?** (Be specific as to what would prevent the injury, incident or damage from occurring again)

  
  
  
  
  
  
  
  

### CORRECTIVE ACTIONS TRACKING (All Blocks Must be Filled In and Information Verifiable)

List action(s) that have or will be taken to prevent a recurrence.	Assigned To Whom	Scheduled Completion Date	Actual Completion Date	Follow-up Date

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#### JOB HAZARD ANALYSIS REVIEW

Is there a JHA that applies to the **task** being performed when the injury or incident occurred?  Yes  No  
*If yes, review the JHA, answer the following questions, and attach a copy to this report.*  
*If no, please explain why the JHA was not required for the task.*

Were hazards sufficiently identified? If not, please explain.  Yes  No

Were identified controls adequate and implemented? If not, please explain.  Yes  No

Were the identified controls not implemented? If not, please explain.  Yes  No

#### INVESTIGATION TEAM (Print and Sign)

Signature	Name	Title

cc:

Attachments