



State of Oklahoma

WORKERS' COMPENSATION INCIDENT INVESTIGATION REPORT

Check Box: INJURY ILLNESS NEAR MISS

Email completed form to: tnwclaims@tnwinc.com or fax to: 800-748-6159

A. EMPLOYEE INFORMATION: ALL FIELDS REQUIRED

Form with fields for Employee's Name, M/F, DOB, SSN, Job Title, Employee ID Number, Agency #, Dept, Overtime, Shift, etc.

B. INCIDENT DETAILS: Is there any reason to question how this incident occurred? Yes No Explain:

Form with fields for Location/Address and Describe what happened.

C. WAS MEDICAL TREATMENT REQUIRED? Yes No

Form with numbered questions about medical treatment.

D. PART OF BODY INVOLVED (be specific: left, right, upper, lower, etc.)

Empty form box for part of body involved.

E. TYPE OF INCIDENT

Form with checkboxes for types of incidents like Caught on or in, Ingestion, Inhalation, etc.

F. WITNESS TO INJURY (attach witness statement to investigation page 2)

Form with fields for Name #1, Phone #, Name #2, Phone #.

G. FORM COMPLETED BY:

Form with fields for Print Name & Title, Phone # & Email Address, Date & Time Injury Reported to Agency.

H. SUPERVISOR'S INVESTIGATION OF INCIDENT

WHAT HAPPENED? (Be specific; include heights, weight, repetitions, dimensions, lighting etc.)

I. WHY DID IT HAPPEN?

ROOT CAUSE #1:

ROOT CAUSE #2:

ROOT CAUSE #3:

J. WHAT CORRECTIVE ACTION IS BEING TAKEN TO ELIMINATE POTENTIAL FOR FURTHER INJURY OR ILLNESS?

What specifically is being done? How are we addressing root causes, behavior, hazards, training?

K. DISCIPLINARY ACTION TAKEN: YES NO

Describe:

L. FALL FROM DIFFERENT LEVEL INFORMATION:

Height:

Was a ladder involved? Describe:

M. CAUSE OF INCIDENT – UNSAFE ACT: BY INJURED PERSON -or- BY OTHER PERSON (NAME):

- | | | |
|---|--|--|
| <input type="checkbox"/> Failure to warn or signal | <input type="checkbox"/> Working/reaching moving equipment | <input type="checkbox"/> Overloading equipment or containers |
| <input type="checkbox"/> Making safety devise inoperative | <input type="checkbox"/> Failure to shut off or lockout | <input type="checkbox"/> Wearing unsafe attire, jewelry etc. |
| <input type="checkbox"/> Not observing where walking or driving | <input type="checkbox"/> Moving objects too heavy | <input type="checkbox"/> Disregard instructions |
| <input type="checkbox"/> Operating at unsafe speed | <input type="checkbox"/> Not wearing PPE | <input type="checkbox"/> Horseplay |
| <input type="checkbox"/> Operating without safety device | <input type="checkbox"/> Operating without authority | <input type="checkbox"/> Lack of training |
| <input type="checkbox"/> Taking unsafe position | <input type="checkbox"/> Using unsafe tools or equipment | <input type="checkbox"/> No unsafe act |
| <input type="checkbox"/> Negligence | <input type="checkbox"/> Employee misconduct | <input type="checkbox"/> Other _____ |

N. CAUSE OF INCIDENT – UNSAFE CONDITION

- | | | |
|--|--|---|
| <input type="checkbox"/> Hazardous arrangement | <input type="checkbox"/> Poor Housekeeping | <input type="checkbox"/> Wet/slippery/icy floor or ground |
| <input type="checkbox"/> Insufficient lighting | <input type="checkbox"/> Unsafe design | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Insufficient guarding | <input type="checkbox"/> Ergonomic deficiency | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Faulty machine or equipment | <input type="checkbox"/> Hazardous work method | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Insufficient ventilation | <input type="checkbox"/> Poor air quality | <input type="checkbox"/> Other _____ |

O. CAUSE INFORMATION

- | YES | NO | |
|-----------------------------|--------------------------|---|
| 1. <input type="checkbox"/> | <input type="checkbox"/> | Was employee doing his/her regularly assigned job? Explain a "no" answer below. |
| 2. <input type="checkbox"/> | <input type="checkbox"/> | Did you (supervisor) provide proper instruction on how to do the job safely? Explain a "no" answer below. |
| 3. <input type="checkbox"/> | <input type="checkbox"/> | Was employee doing this job as you had instructed? Explain a "no" answer below. |
| 4. <input type="checkbox"/> | <input type="checkbox"/> | Was proper equipment provided? Explain a "no" answer below. |
| 5. <input type="checkbox"/> | <input type="checkbox"/> | Was the employee using the equipment? Using it properly? Explain a "no" answer below. |
| 6. <input type="checkbox"/> | <input type="checkbox"/> | Have you had similar incidents with this or other equipment in you area? Explain a "yes" answer below. |

Additional comments from above:

P. SAFETY INVESTIGATION AND FOLLOW-UP

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Was the investigation thorough? |
| <input type="checkbox"/> | <input type="checkbox"/> | Was corrective action taken? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the supervisor make every attempt to help eliminate the unsafe act or hazard? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the employee make every attempt to help eliminate the unsafe act of hazard? |

Explanation and recommendations:

Q. INVESTIGATION COMPLETED BY:

Print Name & Title	Phone # & Email Address	Date Completed
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