



Environmental Health, Safety & Insurance

Supervisor's Injury / Illness Analysis and Prevention Report

Austin Community College
 EHS & Insurance Office
 9101 Tuscany Way
 Austin, Texas 78754
 (512) 223-1015

Instructions:

1. Complete this report within 24 hours of being notified of a work related injury or illness.
2. If you were not present at the time of injury, Interview employee to obtain details.
3. Send the completed and signed report to Environmental Health Safety & Insurance Office (email, Fax to 512-223-1035, or hand carry).

Employee / Student Information			
Employee / Student Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Home Mailing Address	City	State	Zip
Home Phone	Date of Birth	Social Security Number	
Date of Hire(NA for Students)	Job Title(NA for Students)	Classification (NA for Students)	
Marital Status (NA for Students) <input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown			
Occurrence Information			
Date of Injury / Illness	Time Injury Occurred	Date Injury / Illness Reported to Supervisor	
Time Employee Began Work (ex: 8:15)	Location Where Injury / Illness Occurred	Witnesses (Names, Addresses, Phone Numbers)	
Name of Supervisor / Faculty	Supervisor / Faculty Phone	Type of Injury / Illness	
Describe how the injury / illness occurred, including the action , occurrence or event that caused the injury / Illness			
List all equipment, material, or chemicals employee was using when accident or illness occurred			Were Safeguards or Safety Equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill.			
Injury / Illness Factors (Check all that apply and explain below) Was the Injury / Illness due to <input type="checkbox"/> an unsafe act <input type="checkbox"/> unsafe condition or <input type="checkbox"/> both?			

<input type="checkbox"/> Slippery / uneven surface	<input type="checkbox"/> Fatigue influenced action	<input type="checkbox"/> Ignored known hazard
<input type="checkbox"/> Trip Hazard	<input type="checkbox"/> No documented procedure	<input type="checkbox"/> Tried to avoid effort
<input type="checkbox"/> Lifting / Material handling	<input type="checkbox"/> Less than adequate procedure	<input type="checkbox"/> Did not know safe procedure
<input type="checkbox"/> Repetitive Activities	<input type="checkbox"/> Defective Tool, Equipment or machinery	<input type="checkbox"/> Less than adequate design
<input type="checkbox"/> Chemical Exposure	<input type="checkbox"/> Use of wrong tool, equipment or machinery	<input type="checkbox"/> Inattention
<input type="checkbox"/> Unaware of hazard	<input type="checkbox"/> Failure to use Personal Protective Equipment	<input type="checkbox"/> Weather Conditions
<input type="checkbox"/> Tried to save time	<input type="checkbox"/> Failure to follow proper procedures	<input type="checkbox"/> Temperature
	<input type="checkbox"/> Lack of (or improper) Training	<input type="checkbox"/> Unable to determine

Explanation:

Corrective Actions:

Has employee / student received prior training in how to properly perform the task in which he / she was injured? If Yes, date training was provided _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Is training or retraining recommended to correct unsafe behavior? If "yes", type of training scheduled _____ date of scheduled training _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Does the affected employee / student have any recommendation to prevent this injury from recurring? If "yes", explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Does the Supervisor / Instructor agree with this recommendation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

List corrective actions taken by Supervisor / Instructor to prevent this injury / illness from recurring.

Treatment Information

The following questions will provide information that is required in order to meet regulatory requirements and for annual reporting. You may need assistance from the injured employee to complete some of the questions. The following questions are not applicable to student injuries.

Physician / Health care provider name (Last, First, MI)			
Address	City	State	Zip

Did the employee receive restrictions due to the injury / accident? If yes, please identify what the restrictions were.

Did restrictions prevent employee from performing essential functions of their job assignment? Was employee given temporary assignment to another area?	Date restrictions began	Date removed from restrictions
Did employee receive any Doctor Ordered time away from work due to injury / accident?	Date absence due to Dr. orders began	Date employee released by Physician to return to work

Please have employee provide documentation for return to work authorization from Physician, if previously given physicians orders not to return to work.

Date submitted to Environmental Health Safety and Insurance Office _____

Name of person completing form _____ Date _____