OSHA Case #:_____

ISD 885 St Michael Albertville

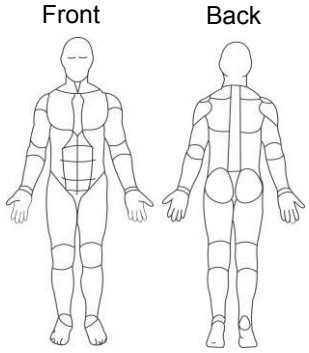
Accident / Illness Report & Analysis Form

EMPLOYEE SOCIAL SECURITY NUMBER		TODAY'S DATE		SUPERVISOR (at time of injury)	
DATE OF CLAIMED INJURY	TIME OF INJURY (AM / PM)	TIME EMPLOYEE STARTED WORK ON DAY OF INJURY: AM PM			DATE REPORTED
EMPLOYEE NAME (last, first, middle)		GENDER: Male Female		MARRIED: YES NO	
HOME ADDRESS		HOME PHONE NUMBER		DATE OF BIRTH	
CITY, STATE, ZIP CODE		OCCUPATION		DEPT.	DATE HIRED
LOCATION OF ACCIDENT	PART OF BODY AFFECTED	NATURE OF ACCIDENT (i.e. - slip/fall, strain, cut)			

ACCIDENT CONDITIONS

INDOORS	**OUTDOORS**
NATURE OF ACTIVITY	NATURE OF ACTIVITY
WHAT WAS THE ISSUE?	WHAT WAS THE ISSUE?
ENVIRONMENTAL / CHEMICAL FACTORS	WEATHER & SURFACE CONDITIONS

EMPLOYEE's WRITTEN STATEMENT OF WHAT HAPPENED (Be DETAILED & indicate areas affected on body image below)



WITNESS STATEMENT OF WHAT HAPPENED

Witness name:_____

OSHA Case #:_____

ACCIDENT CAUSES

EQUIPMENT / TOOLS **N/A**

What equipment was involved?

_____

Was the wrong tool or piece of equipment used? **____Yes ____No**

Was there an unsafe condition involved with the tool? **____Yes ____No**

Corrective action required?: __Repair __Replace ___Other:_____

SURROUNDINGS			**CORRECTIVE ACTIONS RECOMMENDED**
Poor Lighting?	**____Yes**	**____No**	_____
Poor Access?	**____Yes**	**____No**	_____
Poor Housekeeping?	**____Yes**	**____No**	_____
Poor Visibility?	**____Yes**	**____No**	_____
Vehicle / Eq. Involved?	**____Yes**	**____No**	_____

EMPLOYEE **Length of employment in years: ____1-2 ____2-5 ____6-10 ____11-15 _____16+**

New employee? **____Yes ____No** **____0-1 mo. ____2-6 mo. ____7-12 mo.**

Was employee new to job? **____Yes ____No** If Yes, why? _____

Was employee trained? **____Yes ____No** If No, why? _____

Was employee at fault? **____Yes ____No** If Yes, how? _____

_____

Did the accident involve?:

_____Horseplay _____Inattention _____Poor Judgment _____Unauthorized Operatior _____Student

Explain answer(s) to above: _____

_____

_____

PROCEDURE

Was there a procedure associated with the task at the time of the accident? **____Yes ____No**

If Yes, was it being followed correctly: **____Yes ____No**

If No, why? _____

Did the procedure fail to prevent the accident? **____Yes ____No**

If Yes, how _____

_____

Corrective Actions Recommended (CAR) at this time: _____

_____

SUPERVISOR

Do you think this was a preventable accident? **____Yes ____No** (Explain)

Was the job properly planned and staffed? **____Yes ____No** (If No, explain)

Was the job properly supervised? **____Yes ____No** (If No, explain)

Have similar accidents occurred in the past? **____Yes ____No** (If No, explain)

Explain / Comment: _____

_____

_____

_____

OSHA Case #:_____

IMMEDIATE ACTIONS TAKEN

EMPLOYEE:

First Aid ____**Yes** ____**No**
Medical Attention ____**Yes** ____**No**
Rest / Modified Duty ____**Yes** ____**No**
Other:_____

EQUIPMENT

_____Locked-Out
_____Repaired
_____Replaced
_____Discarded
_____Other

SURROUNDINGS

_____Modified
_____Cleaned-up
_____Posted
_____Evacuated
_____Other

Explain the above: _____

SUMMARY OF CORRECTIVE ACTIONS RECOMMENDED AT THIS TIME

EMPLOYEE: _____

PROCEDURE: _____

TRAINING: _____

EQUIPMENT/TOOLS: _____

SURROUNDINGS: _____

ADDITIONAL FACTS / INFORMATION

Were photographs taken? ____**Yes** ____**No** If yes, what type: __ 35mm __ digital __video
Were authorities brought in? ____**Yes** ____**No** If yes, explain: _____

ACKNOWLEDGEMENTS

	SIGNATURE	*DATE*
EMPLOYEE	_____	_____
SUPERVISOR	_____	_____
ADMINISTRATOR	_____	_____

Date reviewed by Safety Committee _____

Minnesota workers' compensation system employee information sheet

What does workers' compensation pay for?

- Medical care for the work injury, as long as it is reasonable and necessary
- Wage-loss benefits for part of your lost income (there is a three-calendar-day waiting period before these benefits start)
- Benefits for permanent damage or loss of function of a body part
- Benefits to your spouse and/or dependents if you die of a work injury
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer

How are workers' compensation benefits paid?

Your workers' compensation benefits are paid by an insurance company or your employer, if your employer is self-insured. State law sets the benefit levels. Please note: pursuant to statute, the insurer can obtain medical information specific to your work injury without your authorization.

If the insurer accepts your claim for wage loss benefits and you have been disabled for more than three calendar days:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating your claim is accepted.

- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

If the insurer denies your claim for wage loss benefits:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.

- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.

Insurer name: Phone :

- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below to see what to do next.

If you have other questions or need more help, call the Minnesota Department of Labor and Industry Workers' Compensation Hotline:

Twin Cities and Southern Minnesota: **(651) 284-5005 or 1-800-342-5354; TTY (651) 297-4198**
Duluth and Northern Minnesota: **(218) 733-7810 or 1-800-342-5354**

Your call will be answered by experienced workers' compensation specialists, who will provide **instant, accurate information and assistance.**

Additional workers' compensation information is available on the department's Web site at:
www.dli.mn.gov/WorkComp.asp

Your employer is required by law to give you this information. This material can be made available in different formats, such as large print, Braille or audio, by calling the numbers printed above.