

**SOUTH CAROLINA COUNTIES WORKERS' COMPENSATION TRUST
ACCIDENT INVESTIGATION FORM**

1. Member:	2. Employee Name:
3. Department:	4. Exact Location:
5. Date and Time of Accident:	6. Date Reported:
7. Please describe clearly how the accident occurred:	
8. Witnesses & Their Telephone Numbers:	

DIRECT CAUSES				BASIC CAUSES	
UNSAFE ACTS		UNSAFE CONDITIONS		WORK SYSTEM	
	Lack of skill or knowledge		Inadequate guards or protection		Inadequate hiring/placement practices
	Failure to follow operating or maintenance procedure/method		Defective tools, equipment, machine or vehicle		Inadequate enforcement of work rules and procedures
	Failure to use guards provided		Congested work area/roadways		Inadequate job instruction/training
	Failure to use personal protective equipment		Unsafe floors, ramps, stairways, platforms		Inadequate safety procedures
	Making safety devices inoperable		Poor housekeeping		Inadequate preventive maintenance
	Operating vehicle, equipment or machine at unsafe speed or in an unsafe manner		Hazardous atmosphere: gases, dust, fumes, vapors		Inadequate environmental control program
	Using known defective equipment		Hazardous chemicals/substances		Inadequate job planning methods
	Operating without authority		Inadequate warning system		Improper layout or design of work area
	Improper lifting, lowering or carrying technique		Fire or explosion hazards		Unsafe design or construction of tools, equipment or machine
	Taking unsafe position		Improper material storage		Inadequate medical monitoring
	Influence of alcohol or drugs		Inadequate ventilation		Inadequate supervision
	Physical or mental limitations		Excessive noise		Other—explain in detail
	Unaware of hazards		Inadequate illumination		
	Unsafe act of non-employee		Poor road conditions		
	Other—explain in detail		Limited visibility	INDIVIDUAL	
			Adverse weather		
			Other—explain in detail		Pre-existing physical condition
					Physical impairment due to drug use
				Employee insubordination or dishonesty	

Very important: Please document what corrective actions were taken, by whom and when. Often it may be necessary to send the accident investigation to the risk manager before all corrective actions are completed. Send another copy of this page to the risk manager when all corrective actions are completed. This may take several weeks. The investigation should remain in an “active” status until all corrective actions have been taken and documented.

9. What actions have been or will be taken to remove Direct Causes? List all items in sequence:	By Whom:	When:
10. What actions have been taken to remove the Basic Causes? List steps that will be taken to remove the Basic Causes to help prevent similar accidents in the future.	By Whom:	When:

Very important: please complete this page if the employee was injured in a motor vehicle accident.

Motor Vehicle Accident Investigation Form	
Employee/driver name:	Department:
Vehicle make/model/year:	Vehicle mileage:
Did police report state that employee contributed to the accident? Yes No	Was employee cited? Yes No If yes, which violation was cited?
Was employee drug tested? Yes No	Was employee wearing a seat belt? Yes No
How could the employee have avoided the accident?	Did the employee receive sanctions? Yes No If yes, list sanctions:
Has this employee had previous motor vehicle accidents in county vehicles? Yes No If yes, please describe briefly:	When was the last motor vehicle record reviewed for this driver?
Has this employee taken a defensive driving class? Yes No If yes, what was the name of the class and when was it taken?	