TASB RISK MANAGEMENT FUND

Incident Investigation Record

This form is for recordkeeping and loss control purposes. Do not send this form to TASB or to the Texas Workers' Compensation Commission (TWCC). Using this form will benefit you in three ways:

1. Incident investigation assists you in reducing or preventing future occupational injuries and illnesses.
2. This form requests all the information that TWCC says you must record for each on-the-job injury, fatality, and occupational disease. Employers must keep injury records for five years after the last day of the year in which the injury occurred.
3. This form is a good source of information if you need to complete a first report of injury. You must file a first report of injury with your insurance carrier for each on-the-job injury.

THIS INCIDENT is an		Injury		Disease		Fatality		Near-miss

Today's Date:	Date Reported:

District: *Belton Independent School District*	Department:
Supervisor	Phone No.

Name of Person Involved:	Sex:	Social Security Number:	DOB:	Date of Incident:

Home Address:	Time and Day of Incident: am pm		Specific Location of Incident:
			Day of week:

Phone:	Employee Occupation:	Job Task at Time of Incident:
Name & Address of Treating Physician:	Length of Service: _____ years _____ months	Employee was Working: Alone / With Fellow Workers / Other
	Employment Category: _____ Regular, full-time; _____ regular, part-time; _____ Seasonal; _____ Temporary; _____ Non-employee	Experience in Occupation at Time of Incident: _____ Less than 1 month; _____ 1 to 5 months; _____ 6 months to 1 year; _____ 1 to less than 5 years; _____ 5 or more years
Name & Address of Hospital:	Phase of Employee's workday at Time of Injury: _____ During break period; _____ During meal period; _____ Working overtime; _____ Entering or leaving the building; _____ Performing work duties; _____ Other (explain below)	
Employee's Wage (pay per hour):	Employee's immediate supervisor at time of incident:	Did he/she witness incident? Yes / ____No
Voluntary benefits paid by the employer?	Other Witnesses:	

Part of body injured or affected:

___Skull, scalp	Jaw	Abdomen	Shoulder: R/L	Wrist: R/L	Knee: R/L	Foot: R/L
___Eye: R/L	Neck	Back	Upper Arm: R/L	Hand: R/L	Thigh: R/L	Toe: R/L
___Nose	Spine	Pelvis	Elbow: R/L	Finger: R/L	Lower Leg: R/L	Other:
___Mouth	Chest	Other Body Part	Forearm: R/L	Hip: R/L	Ankle: R/L	
___Skull, scalp						

Nature of Injury:

___Puncture	Bruise, Contusion	Skin Disorder	Amputation	Muscle Sprain	Cumulative Trauma Disorder
___Laceration	Dislocation	Burn	Insect/Animal Bite	Muscle Strain	Irritation
___Fracture	Abrasion	Respiratory	Foreign Body	Hernia	Infection
___Heat/Cold Stress	Hearing Loss	Chemical Exp.	Other		

Disposition:
___Days away from work
___Restricted workdays
___returned to work

Diagnosis:

Severity:
___First Aid ___Medical Treatment
___Lost Work Days ___Fatality Date
___Other

Sent to: ___Doctor ____Hospital

What condition of tools, equipment, or work area contributed to incident? Not Applicable

___Close Clearance Congestion	Floors/Work Surfaces	Inadequate Housekeeping	Defective Tools/Equipment/Vehicle
___Hazardous Placement	Inadequate Ventilation	Equipment Failure	Illumination
___Inadequate Warning System	Equipment/Workstation Design	Inadequate Guards/Barriers	Inadequate/Improper P.P.E.

What caused or influenced substandard conditions? No Sub-standard Conditions

Abuse or Misuse	Inadequate Supervision	Inadequate Purchasing	Inadequate Engineering
Inadequate Maintenance	Inadequate Tools/Equipt/Mat.	Improper Work Surfaces	Wear and Tear
Lack of Knowledge/Training	Improper Motivation	Inadequate Capacity	Lack of Skill

What action or inaction contributed to the incident? ___Not Applicable

___Failure to Make Secure	Under Influence Drugs/Alcohol	Failure to Warn/Signal	Inadequate/Improper P.P.E. Use
___Nullified Safety/Control Devices	Used Defective Equipment	Horseplay/Distractive Action	Operating at Improper Speed
___Used Equipment Improperly	Improper Lifting	Operating Procedure Deviation	Running/Rushing/Acting in Haste
___Improper Loading	Unauthorized Actions	Used Wrong Tool/Equipment	None
___Improper Technique	Improper Position	Servicing Operating Equipment	Other

Probable recurrence:
___Frequent
___Occasional
___Rare

Loss Severity Potential:
___Major
___Serious
___Minor

Preventive Measures: (What corrective actions have been taken or are planned to prevent a recurrence?)

___Improve Enforcement	Improve Clean-up Procedures	Repair/Replace Equipment	Corrective Counseling
___Improve Storage/Arrangement	Rotation of Employee	Eliminate Congestion	Improve/Change Work Method
___Identify/Improve P.P.E.	Install/Revise Guards/Devices	Task Analysis to be Completed	Task Analysis/Procedure Revision
___Improve Design/Construction	Job Reassignment of Employee	Use Other Materials/Supplies	Improve Illumination
___Mandatory Pre-Job Instructions	Improve Ventilation	Reinstruction of Employee	Other

Employee's description of incident (attach sheet for additional comments)

_____
Signature of Employee

Supervisor's description of incident (attach sheet for additional comments)

Specific corrective actions or preventive measures taken:

Corrective Action Taken	Person Responsible	Target Date	Date Completed

_____ _____ _____ _____
Supervisor's Signature Date Manager's Signature Date

_____ _____ _____ _____
Personnel Representative's Signature Date Safety Coordinator's Signature Date