

**ACCIDENT INFORMATION**

Who saw the accident: Name: \_\_\_\_\_ Title: \_\_\_\_\_

Who reported the accident: Name: \_\_\_\_\_ Title: \_\_\_\_\_

Did you lift from: Ground Bench Platform Box Pallet Other

Do you use hand or foot levers: Yes No Do you work overhead: Yes No

Do you have to reach: Yes No Explain: \_\_\_\_\_

Is your work area cluttered: Yes No Explain: \_\_\_\_\_

Do you push or pull: Yes No Explain: \_\_\_\_\_

Do you pick up or lift: Yes No How Much: \_\_\_\_\_ How Often: \_\_\_\_\_

Do you lift in and out of a machine: Yes No If so, do you: Sit Stand Kneel

Location of injury: \_\_\_\_\_ Date of injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Time of day injury happened: \_\_\_\_\_

Activity being performed: \_\_\_\_\_

Please describe the accident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WORKPLACE INFORMATION**

Type of flooring: Rough Smooth Wood Concrete Steel Other

If other, explain: \_\_\_\_\_

Type of lighting: Overhead Fluorescent On Machine Other

If other, explain: \_\_\_\_\_

Is your work area: Oily Dirty Slippery Other

If other, explain: \_\_\_\_\_

Do you have any other jobs: Yes No

If yes, what type: \_\_\_\_\_

Type of windows: Open Closed No Windows

Type of shop: Union Non-Union

Are you tired when you go home: Yes No