

Completed by \_\_\_\_\_  
 Title \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_ Date \_\_\_\_\_

- Near-Miss
  - First Aid
- File 801, if boxes below are checked**
- Medical Care
  - Time Loss
  - Fatal

# Accident Analysis – OSHA’s Form 301

## Information about the employee

1. Full Name: \_\_\_\_\_  
 Dept: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_
2. Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_
3. Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_
4. Date of hire \_\_\_\_/\_\_\_\_/\_\_\_\_
5.  Male  
 Female

Do not supply information in questions 3 – 5 of Safety Committee’s copy.

## SYSTEM CHALLENGES

### Management Do we have:

- Policy Enforcement
- Hazard Recognition
- Accountability
- Supervisor Training
- Corrective Action
- Production Priority
- Proper Resources
- Job Safety Training
- Hiring Practices
- Maintenance
- Adequate Staffing

### Employee

#### Was the employee:

- Following Procedure
- Training
- Previous Injury
- Mental Ability
- Physical Capacity
- Equipment Use
- Short Cuts
- PPE Worn
- Safety Attitude

### Equipment

#### Do we have:

- Proper Tool Selection
- Tool Availability
- Maintenance
- Visual Warnings
- Guarding

### Environment

#### What about:

- Site Layout
- Chemical
- Temperature
- Noise
- Radiation
- Weather
- Terrain
- Vibration
- Ergonomics
- Lighting
- Ventilation
- Housekeeping
- Biological

### Additional Cause

#### Factors:

- Faulty Equipment Non-employee
- Prior Injury
- Late reporting
- Off-the-Job Injury

(Explain any checked boxes on separate sheet)

## Information about the physician or other health care professional

6. Name of physician or other health care professional \_\_\_\_\_
7. If treatment was given away from the worksite, where was it given?  
 Facility \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_
8. Was employee treated in an emergency room?  
 Yes  
 No
9. Was employee hospitalized as an over night patient?  
 Yes  
 No
10. List witnesses and phone numbers: \_\_\_\_\_
11. Identify factors which contributed to or caused accident (refer to list on left side of page):

<b>Management:</b>	<b>Employee:</b>
<b>Equipment</b>	<b>Environment</b>

<b>Counter Measures/Best Practices:</b> How do we correct areas identified in the MEEE area above, who will make changes and when will changes be completed.	<b>W ho &amp; By When</b>
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## Information about the case

12. Case number from the Log \_\_\_\_\_ (transfer the case number from the log after you record the case.)
13. Date of injury or illness \_\_\_\_/\_\_\_\_/\_\_\_\_
14. Time employee began work \_\_\_\_\_ AM/PM
15. Time of event \_\_\_\_\_ AM/PM       Check if time cannot be described
  
16. **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or materials the employee was using. Be specific. Example: "climbing a ladder while carrying roofing materials"; "spraying chlorine from a hand sprayer"; "daily computer key-entry"
  
  
  
  
  
  
  
  
  
  
17. **What happened?** Tell us how the injury occurred. Example: "when ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
  
  
  
  
  
  
  
  
  
  
18. **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; Be more specific than "hurt," "pain," or "sore." Example: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
  
  
  
  
  
  
  
  
  
  
19. **What object or substance directly harmed the employee?** Examples: "concrete floor"; "chlorine"; "radial arm saw." **If this question does not apply leave it blank.**
  
  
  
  
  
  
  
  
  
  
20. **If employee died, when did death occur?** Date of death \_\_\_\_/\_\_\_\_/\_\_\_\_