



WESTERN ALLIED CORPORATION

Supervisors Accident Report

Job Site: _____ Date of accident: _____ Time of Injury: _____

Job Site Address: _____

- | | |
|--|--|
| 1. <input type="checkbox"/> Sheet Metal | 1. <input type="checkbox"/> Foreman |
| 2. <input type="checkbox"/> Piping | 2. <input type="checkbox"/> Journeyman |
| 3. <input type="checkbox"/> Start-Up | 3. <input type="checkbox"/> Apprentice |
| 4. <input type="checkbox"/> Service Tech | 4. <input type="checkbox"/> Other: _____ |

Name of injured employee: _____ Empl# _____

Supervisor: _____ Length of employment: _____

Start of Shift: _____ Length of time on this job: _____

Body Part Injured: _____ What Caused the Injury: _____

Witness: _____ Witness Phone # _____

Treatment: ☐ Hospital ☐ Doctor ☐ Clinic ☐ First Aid ☐ Name of person/facility _____

Nature of Injury

- | | | |
|---|--|--|
| 1. <input type="checkbox"/> Cut | 6. <input type="checkbox"/> Amputation | 11. <input type="checkbox"/> Dislocation |
| 2. <input type="checkbox"/> Bruises/contusions | 7. <input type="checkbox"/> Hernia | 12. <input type="checkbox"/> Electric Shock |
| 3. <input type="checkbox"/> Sprain/strain | 8. <input type="checkbox"/> Abrasions | 13. <input type="checkbox"/> Heat Exhaustion |
| 4. <input type="checkbox"/> Fracture | 9. <input type="checkbox"/> Dermatitis | 14. <input type="checkbox"/> Other: _____ |
| 5. <input type="checkbox"/> Burn (heat, chemical) | 10. <input type="checkbox"/> Poisoning | |

Accident Type

- | | | |
|---|---|--|
| 1. <input type="checkbox"/> Contact with | 5. <input type="checkbox"/> Struck by | 8. <input type="checkbox"/> Overexertion |
| 2. <input type="checkbox"/> Caught in, on or between | 6. <input type="checkbox"/> Fall on same level | 9. <input type="checkbox"/> Other _____ |
| 3. <input type="checkbox"/> Struck by | 7. <input type="checkbox"/> Fall to different level | |
| 4. <input type="checkbox"/> Inhalation, absorption, ingestion | | |

Describe the accident including the equipment involved. Give all details, using additional sheets if necessary.

Unsafe Acts

- | | |
|---|---|
| 1. () Violation of safety rule | 8. () Unsafe handling, lifting or carrying |
| 2. () Horseplay, distracting, teasing | 9. () Bypassing safety devices |
| 3. () Not using personal protective equip. | 10. () Failure to warn/secure |
| 4. () Operating without authority | 11. () Working on moving equipment |
| 5. () Operating at unsafe speeds | 12. () No unsafe act |
| 6. () Using defective equipment | 13. () Other _____ |
| 7. () Unsafe use of tools/equipment | _____ |

Unsafe Conditions

- | | |
|--------------------------------------|---|
| 1. () Inadequately guarded | 8. () Improper ventilation |
| 2. () Unguarded | 9. () Improper dress |
| 3. () Guard not replaced | 10. () Congested area |
| 4. () Defective tools | 11. () Climate (wind-blown object, etc.) |
| 5. () Unsafe design or construction | 12. () Poor housekeeping |
| 6. () Hazardous arrangement | 13. () No unsafe condition |
| 7. () Improper illumination | 14. () Other _____ |

Contributing Factors

- | | |
|---------------------------------------|---|
| 1. () Failure to follow instructions | 4. () Insufficient training |
| 2. () An act of other persons | 5. () Failure to get medical attention |
| 3. () Lack of knowledge | 6. () Other _____ |

Injured Employee Comments – What caused the unsafe condition to exist and how could it have been discovered and corrected?

Injured Employee Comments – If you were asked to do the exact same thing again, what would you do differently?

Supervisor – What caused the unsafe condition to exist and how could it have been discovered and corrected?

Safety Team – What will be done to prevent this from happening again?

Supervisor signature _____ Date _____

Superintendent signature _____ Date _____