



Supervisor's Injury / Illness Analysis And Prevention Report

Austin Community College
EHS and Insurance Office
9101 Tuscany Way
Austin, Texas 78754
(512) 223-1015

Instructions:

- 1. Complete this report within 24 hours of being notified of a work related injury or illness.
2. If you were not present at the time of injury, interview employee to obtain details.
3. Send the completed and signed report to Environmental Health Safety and Insurance Office (e-mail, Fax to 223-1035 or hand carry).

Employee / Student Name _____ Male Female

Job Title (NA for students) _____

Date of Birth _____ Last four digits of Social Security # _____ Date of Hire (NA for students) _____

Home Mailing Address _____ Home Phone _____

Date and Time of Injury / Illness _____ A.M. P.M.

Date Injury / Illness Reported to Supervisor _____ Name of Supervisor _____

Location Where Injury / Illness Occurred _____

Witnesses: (names, addresses, phone numbers) _____

Injury / Illness Descriptions:

Describe how the injury / illness occurred, including the action, occurrence or event that caused the injury / illness.

Describe the injury / illness the employee/student sustained.

The following questions will provide information that is required in order to meet regulatory requirements and for annual reporting. You may need assistance from the injured employee to complete some of the questions. These questions are not applicable to student injuries.

Has the employee ever reported any previous physical condition(s) associated with work or non-work activities (I.E. second job, sports, etc.) that could be related to or aggravated by this injury/illness? Yes No If "Yes," please explain. _____

Name and address of Medical Provider utilized (Concentra ProMed and St. David's Occupational Health Services are set up as ACC's preferred provider; however, an employee can go to any medical provider that accepts Workers Compensation.): _____

Did employee receive restrictions due to the injury/accident? If yes, please identify what the restrictions were. _____

Date restrictions began: _____ Date removed from restrictions: _____

Did restrictions prevent employee from performing essential functions of their job assignment? Was employee given temporary assignment to another area?

Did employee receive any Doctor Ordered time away from work due to injury / accident?

What dates was employee away from work due to Doctor's orders not to return to work?

Date absence due to Dr. orders began: _____ Date employee released by Physician to return to work: _____

Please have employee provide documentation for return to work authorization from Physician, if previously given physicians orders not to return to work.

Injury / Illness Factors (check all that apply and explain below)

Was the injury / illness due to an unsafe act, unsafe condition, or both?

- | | | |
|---|---|--|
| <input type="checkbox"/> Slippery / uneven surface | <input type="checkbox"/> Defective Tool, Equipment or Machinery | <input type="checkbox"/> Inattention |
| <input type="checkbox"/> Trip Hazard | <input type="checkbox"/> Use of wrong tool, equipment or machinery | <input type="checkbox"/> Weather Conditions |
| <input type="checkbox"/> Lifting / material handling | <input type="checkbox"/> Failure to use Personal Protective Equipment (PPE) | <input type="checkbox"/> Temperature |
| <input type="checkbox"/> Repetitive Activities | <input type="checkbox"/> Failure to follow proper procedures | <input type="checkbox"/> Unable to determine |
| <input type="checkbox"/> Chemical Exposure | <input type="checkbox"/> Lack of (or improper) training | |
| <input type="checkbox"/> Unaware of hazard | <input type="checkbox"/> Ignored known hazard | |
| <input type="checkbox"/> Tried to save time | <input type="checkbox"/> Tried to avoid effort | |
| <input type="checkbox"/> Fatigue influenced action | <input type="checkbox"/> Did not know safe procedure | |
| <input type="checkbox"/> Less than adequate procedure | <input type="checkbox"/> Less than adequate design | |

Explanation:

Corrective Actions:

Has employee / student received prior training in how to properly perform the task in which she / he was injured? Yes No NA

If "yes", date training was provided _____

Is training or retraining recommended to correct unsafe behavior? Yes No NA

If "yes", type of training scheduled _____ Date training scheduled _____

Does the affected employee / student have any recommendations to prevent this injury / illness from recurring? Yes No

If "yes", explain _____

Does Supervisor / Instructor agree with this recommendation? Yes No

List corrective actions taken by Supervisor / Instructor to prevent this injury / illness from recurring.

Date submitted to Environmental Health Safety and Insurance Office _____

Name of person completing form _____ **Date** _____