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U.S. Department of Energy

INDIVIDUAL ACCIDENT/INCIDENT REPORT

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OMB Control No.
1910-0300

General Information

1. Organization Name: _____

Organization Code: |_|_|_|_|_|_|_|

2. Case Number: |_|_|_|_|_|_|_| Revision: ❑ Yes

3. Did accident involve more than one reporting organization?
❑ Yes ❑ No

Multiple Case Number: |_|_|

4. Accident Type: ❑ Injury/Illness ❑ Vehicle
❑ Property Damage ❑ Other

5. Investigation Type: ❑ A ❑ B ❑ C ❑ Non-recordable

6. Department, Division, or I.D. Code: _____

7. Date of Occurrence: |_|_|_|_|_|_|_|_| (Month Day Year (YYYY))

8. Time of Event: |_|_|_|_| (Military)

9. Accident Occurred: ❑ Indoors ❑ Outdoors

10. On Employer's Premise: ❑ Yes ❑ No

11. Specific Location: _____

Employee Information

12. Check One: ❑ Injury/Illness Employee
❑ Operator of Equipment/Vehicle
❑ Not Applicable

13. Name: _____

Home
Address: _____

14. Social Security No. |_|_|_|_|_|_|_|_|_|

15. Date of Birth: |_|_|_|_|_|_|_|_| (Month Day Year (YYYY))

16. Sex: ❑ Female ❑ Male

17. Occupation: _____

18. Time Employee Began Work: |_|_|_|_| (Military)

19. Date of Hire: |_|_|_|_|_|_|_|_| (Month Day Year (YYYY))

20. Experience on this Job/Equipment: ❑ Under 3 Months
❑ 3 to 12 Months
❑ Over 12 Months

(If Property Damage or Vehicle Accident, Go to Line 26)

Injury/Illness (OSHA Information)

21. ❑ Injury Code (10)

Illness Codes
❑ Code 7a(21) - Skin disease or disorders
❑ Code 7b(22) - Dust diseases of lungs
❑ Code 7c(23) - Resp. due to toxic agents
❑ Code 7d(24) - Poisoning
❑ Code 7e(25) - Disorders-Physical agents
❑ Code 7f(26) - Disorders-Repeated trauma
❑ Code 7g(29) - All others

22. Workdays Lost: |_|_|_|_| (Actual if available or estimated expected)

23. Workdays Restricted: |_|_|_|_| (Actual if available or estimated expected)

24. Has employee returned to work with no further anticipated workdays lost or restricted?
❑ Yes ❑ No

25. Permanent transfer to different job because of accident?
❑ Yes ❑ No

Terminated because of accident?
❑ Yes ❑ No

26. Did employee die? ❑ Yes ❑ No

If "Yes," enter date |_|_|_|_|_|_|_|_| (Month Day Year (YYYY))

18 U.S.C. SECTION 1001; ACT OF JUNE 25, 1948; 62 STAT. 749; MAKES IT A CRIMINAL OFFENSE TO MAKE A WILLFULLY FALSE STATEMENT OR PRESENTATION TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES AS TO ANY MATTERS WITHIN ITS JURISDICTION.


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Property/Vehicle Damage

27. Property Loss Type (Select One)

Fire/Smoke: ❑ Building ❑ Brush ❑ Vehicle ❑ Other
Electrical: ❑ Equipment Contact ❑ Wiring ❑ Overload ❑ Insulation ❑ Polarity ❑ Grounding ❑ Other
Explosion: ❑ Vapor ❑ Chemical ❑ Fluids ❑ High Explosives ❑ Dust
Mechanical: ❑ Linear energy ❑ Rotational Energy ❑ Pressure ❑ Falls ❑ Mechanical Breakdown ❑ Overload
Acts of Nature: ❑ Wind ❑ Rain/Hail ❑ Flood ❑ Freezing/Snowlightning ❑ Earthquake ❑ Other
Leaks, Spills, Releases, or Contamination: ❑ Chemical ❑ Nuclear ❑ Environmental Impairment ❑ Other
Miscellaneous: ❑ Thermal ❑ Corrosion ❑ Water Damage ❑ Sabotage ❑ Other

(If Property Damage Accident go to Line 30)

28. Vehicle Type (Select One)

Light Highway: ❑ Automobile ❑ Van ❑ Pickup truck ❑ Motorcycle, moped ❑ Highway vehicle, n.e.c.

Heavy Highway: ❑ Bus ❑ Delivery truck ❑ Dump truck ❑ Semitrailer, tractor trailer, trailer truck ❑ Truck, n.e.c. (e.g., fire truck)

Air Rotary Wing: ❑ Helicopter ❑ Aircraft--rotary wing, n.e.c.

Air Fixed Wing: ❑ Jet ❑ Propeller--driven aircraft ❑ Aircraft fixed wing, n.e.c.

Other Vehicles: ❑ Railroad ❑ Marine

29. Was vehicle equipped with seat belts? ❑ Yes ❑ No
If "Yes," was seat belt in use? ❑ Yes ❑ No

30. Did vehicle accident involve recordable injury? ❑ Yes ❑ No

31. Total Accident Damage $_____

DOE Property/Vehicle $_____

Non- DOE Property/Vehicle $_____

32. Claim Against DOE $_____ Paid by DOE $_____

Reimbursable to DOE $_____ Paid to DOE $_____

33. Are the dollar amounts final? ❑ Yes ❑ No

Equipment/Hardware/Vehicle Involved (as applicable)

34. #1 Equipment _____
Generic (or brand) name and model

#2 Equipment _____
Generic (or brand) name and model

35. Did equipment design or defect contribute to accident cause or severity? ❑ Yes ❑ No

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NARRATIVE GUIDE

DO NOT INCLUDE THE NAME (OR OTHER PERSONAL IDENTIFIER) OF THE EMPLOYEE/OPERATOR OR WITNESS IN THIS SECTION.
Use third person references, e.g., he slipped on the wet floor and broke his right toe.

36. Activity in progress at time of accident. Be specific. For example, if the employee was using, equipment or handling materials or chemicals, name them and tell what he was doing with them.

37. Events Describe the accident sequentially, beginning with initiating events. Tell what happened, how it happened and end with nature and extent of injury/damage. Use a separate sheet for additional space.

Name any objects or substances (e.g., utility knife, glass beaker containing saline solution) involved and tell how they were involved.

Describe the nature of the injury/illness/damage. Name the body part effected if injury or illness. (e.g., amputation of right index finger at second joint)

Name and address of primary health care provider (e.g., physician, nurse, etc.) _____

If hospitalized overnight, name and address of hospital _____

38. Accident Causes
a. Conditions

b. Actions

c. Factors influencing a or b.

39. Corrective Actions (if risk is acceptable, corrective action may not be necessary. If so, indicate "Not applicable" in section "a." below.)
a. Actions taken

b. Actions recommended

c. To be completed by _____
Implementation Date

40. Report Prepared by _____ Date _____ Telephone _____

Official Position ❑ Supervisor ❑ Safety Professional ❑ Other

41. Supervisor responsible for Corrective Action _____ Date _____ Telephone _____

42. Accident Investigation Contact
(if different from line 40) _____ Telephone _____