DAS Accident Prevention Review

Employee Section (please print)

Name:	Date of Birth:	Sex: M / F	Employee ID #:
Address:	Phone:	Shift:	Days Off:
Division: Department:	Job Title:	Status: Temp. / Perm.	
Place of Accident:	Date of Accident:	Time of Accident:	

Supervisor: _____ Phone #: _____

(Please Print)

Date Reported: / /	**How long has employee been in this Job:**
Witnesses:	

Environmental Conditions

Circle the items that best identify the conditions during at the time of the Accident.

Weather Conditions: Rain, Wet, Dry, Ice, Snow, **Light Conditions:** Daylight, Foggy, Dark, Cloudy

Clothing Worn: Long Pants, Shorts, Long sleeve shirt, T-shirt, Dress, Sweater, Coat, Overalls, Other

Foot Wear: Leather Shoes, Sandals, Heels, Athletic Shoes, Boots, Birkenstocks, Thongs, Other

Incident Review

Body Part Injured: **Left / Right** **Nature of Injury:**

Working Overtime? Yes / No **Reassigned form other area? Yes / No**

Describe Accident in Detail: (This should be done in area where accident occurred)

Describe any Work Conditions That Contributed to Cause of Accident:

If accident was caused by equipment, was it repaired or removed from service? Yes / No

If using improper procedure caused accident, was procedure reviewed, and any additional training needed provided? Yes / No Training needed: Date Scheduled:

Action Taken to correct / Prevent accident:

Employee's signature indicates this accident was reviewed with their supervisor and information is correct.

Employee Signature:	**Date:**
Supervisor Signature:	**Date:**

(If medical treatment is needed Employee must fill out Form 801 within 24 hr.)

Please make copy for employee and your file. Original to Employee Services Section.

Revised: 12/15/08 CK