

Phone Number: _____

Accident Information

Who saw the accident: Name: _____ Title: _____

Who reported the accident: Name: _____ Title: _____

Do you lift from: Ground Bench Platform Box Pallet Other

Do you use hand or foot levers: Yes No Do you work overhead Yes No

Do you have to reach: Yes No Explain: _____

Is your work area cluttered: Yes No Explain: _____

Do you push or pull: Yes No Explain: _____

Do you pick up or lift: Yes No How much: _____ How often: _____

Do you use a cart: Yes No Type of wheels: Rubber Steel Plastic

Condition of cart Good Bad Other

If other, explain _____

of carts moved at once: _____ Weight moved per day: _____

From where to where: _____

Do you lift in and out of a machine: Yes No If so, do you: Sit Stand Kneel

Please describe the accident:

Workplace Information

Type of flooring: Rough Smooth Wood Concrete Steel Other

If other, explain _____

Type of ventilation: Blower A/C Heat Exhaust None Other

If other, explain _____

Type of lighting: Overhead Fluorescent On Machine Other

If other, explain _____

Is your work area: Oily Dirty Slippery Other

If other, explain _____

Do you have any other jobs: Yes No

If yes, what type: _____

Has outside help been hired: Yes No

If yes, why: _____

Type of windows: Open Closed No windows

Type of shop: Union Non-Union

Are you tired when you go home: Yes No