Instructions for filling out the following forms:

- The following forms are being made available as fillable PDF forms. This means that you can type all of the information directly into the forms.
- **WE HIGHLY RECOMMEND** that you download the forms to your PC **BEFORE** you begin filling them out.
- Filling these forms out in Acrobat Reader on your PC will allow you to save your forms in progress and save a copy of your completed form for your personal records.
- Filling these forms while they are open in your browser, which is the default behavior, will only allow you to print the completed form. **YOU WILL NOT BE ABLE TO SAVE YOUR WORK.**

FREQUENTLY ASKED QUESTIONS ACCIDENT/INCIDENT/NEAR-MISS REPORTING AND INVESTIGATION FORMS

Why do we perform accident/incident/near-miss investigation?
Accident, incident, and near-miss investigations are performed in order to gather information on the root cause and/or the contributing cause(s) which led to the accident/incident event. Obtaining completed and signed forms as soon as possible following an accident/incident ensures that the employer has an accurate account of how the injury or illness occurred. It also identifies corrective action. Furthermore, conducting an effective investigation is a California Occupational Safety and Health Administration (Cal/OSHA) requirement.

What forms do I need to complete in order to report and investigate an accident/incident/near-miss event?
Accident/Incident/Near-Miss reporting and investigation forms consist of the Employee's Report of Injury/Illness Form, Accident/Incident Witness Statement Form, Supervisor's Investigation Form, and Near-Miss Reporting and Investigation Form. The supervisor shall provide these to the appropriate individuals for completion after any accident or incident. Other reports and forms may be acceptable substitutes, as long as they provide the same information (e.g. use of force investigation, traffic accident investigation).

What forms do I give the employee to complete?
Upon becoming aware of an employee injury or illness, provide and request the employee to complete and submit an Employee's Report of Injury/Illness Form. In addition within 24-hours, provide the injured employee with Workers' Compensation Claim Form (DWC 1) and Notice of Potential Eligibility. If the employee is off work, the form may be mailed or delivered in person.

What if my injured employee is physically unable to fill out the Employee's Report of Injury?
Use common sense and good judgment. If the injury is severe, remember that your employee's health and care are first and foremost. If possible, have the form filled out at a later, more appropriate time when the employee is physically able to document the accident

What if my employee refuses to fill out or sign an Employee's Report of Injury?
Of course, you cannot make an employee fill out the document. You can however stress the importance of getting "their" account of the accident to help prevent the injury from happening again. Also, still obtain the supervisor's report as well as any witness statements.

When do I complete the accident/incident/near-miss investigation forms, and what do I do with them?

Step 1 - for all accidents/incident/near-miss (regardless of the outcome): the supervisor should conduct prompt investigation including taking witness(es) statement. The supervisor shall document his/hers findings, identifying cause(s) that led to the injury/illness event, the action(s) that has been or will be taken to prevent a recurrence on the Supervisor's Investigation Form, and Near-Miss Reporting and Investigation Form as appropriate. The supervisor should forward all completed forms to departmental safety coordinator or designee and keep copies for future reference.

Step 2 - for all accidents that result in the employee filing a workers' compensation claim: in addition to step 1 above, submit a copy of these forms to the Workers' Compensation Division(WCD) along with the Employer's Report of Occupational Injury or Illness (Form 5020), included here, and the Workers' Compensation Claim Form (DWC 1) to the Personnel Department Workers' Compensation Division. Form DWC 1 can be obtained on the City's intranet at:

http://cityforms.ci.la.ca.us/urldisplay.cfm?id=486

Step 3 - for work related accidents that result in a fatality or a serious injury (i.e. loss of a member of the body/amputation, in-patient hospitalization in excess of 24 hours for other than observation, or a serious degree of permanent disfigurement like crushing or severe burns): the supervisor shall, as soon as possible, notify

departmental Safety Coordinator or his/her designee, WCD, and City Safety Administrator. In addition to steps 1 and 2 above, the supervisor or designated staff must report the accident to the nearest Cal/OSHA District office within 8 hours.

For a list of the Ca/OSHA District offices' phone numbers and detailed instructions for reporting serious injuries, please go to the links provided below:
http://www.dir.ca.gov/dosh/report-accident-or-injury.html
http://per.lacity.org/safety/safety_page.htm

Note: Head of the department/office is responsible for distributing a memorandum addressing the City Attorney's Office, WCD, and City Safety Administrator briefly describing the incident and confirming that a notification to Cal/OSHA was made within eight (8) hours of knowledge of the incident.

How can I contact Workers Compensation Division (WCD) or City Safety Administrator?

WORKERS COMPENSATION DIVISION
700 E Temple Street, Room 210
Los Angeles, CA 90012
Mail Stop 391
(213) 473-3333
per.wcdiv@lacity.org

OCCUPATIONAL SAFETY AND HEALTH DIVISION
Najma Bashar, Safety Administrator
520 E Temple Street, Room 129
Los Angeles, CA 90012
(213) 473-7097
Najma.Bashar@lacity.org

Step 4 - Injured employee must be provided with the Medical Provider Network (MPN) Notice relevant to that employee

If the employee is a member of the Los Angeles Police Protective League (LAPPL) provide them with this notice:
http://per.lacity.org/documents/3096_LAPPL_Complete_EE_Notice.pdf

If the employee is a member of one of the following MOUs provide them with this notice:
MOU: 3, 6, 16, 7,10, 11, 37, 34, 9, 62, 12, 2, 13, 4, 8, 14, 15, 17, 18, 36, and 63.

http://per.lacity.org/documents/3095_City_ADR_Complete_EE_Notice.pdf

If the employee is a member of any other MOU provide them with this notice:

http://per.lacity.org/documents/3097_Complete_EE_Notice.pdf

Once the employee has been given the notice have them complete and return the Receipt – Proof of Service form which can be obtained here:
http://per.lacity.org/documents/Receipt-ProofOfService.pdf

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

CITY OF LOS ANGELES PERSONNEL DEPARTMENT
700 EAST TEMPLE STREET, ROOM 210 LOS ANGELES, CA 90012

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME

1a. Policy Number: Self Insured

2. MAILING ADDRESS: (Number, Street, City, Zip)

2a. Phone Number

3. LOCATION if different from Mailing Address (Number, Street, City and Zip)

3a. Location Code: N/A

4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.

5. State unemployment insurance acct.no: N/A

6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)

8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM

9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM

10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)

11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No

12. DATE LAST WORKED (mm/dd/yy)

13. DATE RETURNED TO WORK (mm/dd/yy)

14. IF STILL OFF WORK, CHECK THIS BOX: ☐

15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No

16. SALARY BEING CONTINUED? ☐ Yes ☐ No

17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)

18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)

19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning

20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)

20a. COUNTY

21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No

22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.

23. Other Workers injured or ill in this event? ☐ Yes ☐ No

24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold

25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.

26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY

27. Name and address of physician (number, street, city, zip)

27a. Phone Number

28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)

28a. Phone Number

29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.

Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME

31. SOCIAL SECURITY NUMBER

32. DATE OF BIRTH (mm/dd/yy)

33. HOME ADDRESS (Number, Street, City,Zip)

33a. PHONE NUMBER

34. SEX ☐ Male ☐ Female

35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)

36. DATE OF HIRE (mm/dd/yy)

37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours

37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal

37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED

38. GROSS WAGES/SALARY $ _____ per _____

39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)

Signature & Title

Date (mm/dd/yy)

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

EMPLOYEE'S REPORT OF INJURY/ILLNESS FORM

To be completed by the Employee
Please print clearly and add additional sheet if necessary

Employee's name:		Gender: ☐ M ☐ F
Date of birth: ____/____/____	Contact telephone #:	
Home address:		
City:	State:	Zip Code:
Present job classification:	Department/Division:	
Date of accident/incident:	Time of accident/incident: _____ ☐ a.m. ☐ p.m.	
Date reported:	If date reported different from injury date, give reason:	
Location of accident/incident (address and specific area):		
Describe fully how accident/incident occurred (including events that occurred immediately before the accident/incident). Include relevant photos and diagram as necessary:		
Describe injury or illness sustained due to the accident/incident (e.g., strain, sprain, burn, fracture, etc.):		
Body part(s) affected/injured (e.g., head, back, hand, etc.):		
Name of your supervisor:		Phone #:
Name(s) of witness(es):		Phone #:
Name(s) of witness(es):		Phone #:
When did you report the injury/illness to your supervisor?		
To whom did you report the injury/illness (if other than your supervisor)?		
Do you require medical attention? ☐ Yes ☐ No ☐ Maybe	Have you been treated by a physician for this injury/illness before? ☐ Yes ☐ No	
What can the City of Los Angeles do to help prevent similar accidents/incidents?		
Signature of employee:		Date:

ACCIDENT/INCIDENT WITNESS STATEMENT FORM

To be completed by the Witness

Name of employee involved in accident/incident:		
Name of witness:		
Home address (witness):		
City:	State:	Zip Code:
Contact telephone #:	Is witness a City employee? ☐ Yes ☐ No	
If witness is a City employee, Department/Office assigned:		Job title or occupation:
Date of accident/incident:	Time of accident/incident: ☐ a.m. ☐ p.m.	
Location where the accident/incident occurred (include the address and specific area):		
Describe fully how accident/incident occurred. Include events that occurred immediately before the accident/incident. List all objects and substances involved. Include relevant photos and diagram as necessary.		
Describe bodily injury/illness sustained (be specific about body part(s) affected):		
Recommendation on how to prevent this type of accident/incident from recurring:		
Signature of witness:	Date:	

SUPERVISOR'S INVESTIGATION FORM

To be completed by the employee's Supervisor or other responsible administrative official after a work related accident/incident other than a near-miss incident. Please print clearly and use additional sheet if necessary.

Name of injured employee:		Department/Office assigned:
Job title or occupation:	Length of time in this job class?	Date of accident/incident:
Location where accident/incident occurred: Address: Area:	Employer's premises: ☐ Yes ☐ No External job site: ☐ Yes ☐ No	Time of accident/incident: _____ ☐ a.m. ☐ p.m.

Describe fully how accident/incident occurred. Include events that occurred immediately before the accident/incident. List all objects and substances involved. Include relevant photos and diagram as necessary.

Accident/incident resulted in: ☐ Property Damage ☐ First Aid ☐ Injury/Illness Requiring Medical Treatment ☐ Fatality

Describe the nature and extent of injury/illness and property damage.

Part(s) and side of body affected/injured?	Any prior physical conditions? Yes ☐ No ☐	If yes, describe condition:
What equipment/machine was being used? (if none leave blank)	What task/activity was being performed?	The task/activity was part of ☐ Regular Duty ☐ Special Project

PLEASE SELECT ONE OR MORE OF THE CATEGORIES LISTED BELOW WHICH MAY HAVE LED TO THE ACCIDENT/INCIDENT. USE THE FACTORS LISTED ON THE FOLLOWING PAGE TO DETERMINE THE CAUSE(S).

☐ Lack of Knowledge/Skill/Training
☐ Unsafe Use of Tools/Equipment
☐ Unsafe Condition/Exposure
☐ Traffic Accident (Fill out Form Gen. 88, Automobile Accident Report)
☐ Failure to Follow Policy/Procedures
☐ Unsafe Act
☐ Exercise/Fitness/Drill
☐ Stress/Personal Factors
☐ Repetitive/Forceful/Awkward Work
☐ Use of Force (For Sworn Only)

What is the chance of this accident/incident happening again? ☐ High ☐ Moderate ☐ Low

What action has or will be taken to prevent a recurrence of this accident/incident?

Who has or will take action (Name/Title)?	When will the action be taken (date)?

Did employee promptly report the injury/illness? ☐ Yes ☐ No If no, date reported:

Is modified duty available? ☐ Yes ☐ No ☐ N/A

Supervisor's name:	Supervisor's signature:	Phone #:	Date:

INSTRUCTION: USE THIS LISTING FOR IDENTIFYING CAUSE(S) THAT LED TO THE ACCIDENT/INCIDENT. CHECK ALL THAT APPLY.

	Lack of Knowledge/Skill/Training	☐	Employee had difficulty interacting with co-workers and/or supervisor.
☐	Incident occurred due to inadequate knowledge/skill.		**Unsafe Act**
☐	Training was not available/provided for the associated task.	☐	Employee was operating equipment at an improper speed/capacity.
☐	Employee reported inadequate understanding of training materials.	☐	Employee was involved in horseplay.
☐	Employee was not trained to perform the task.	☐	Employee was not using proper personal protective equipment (PPE).
☐	New work methods were introduced without training.	☐	Employee was in a rush.
☐	Employee did not attend the required refresher training.	☐	Employee failed to use available equipment.
	Unsafe Use of Tools/Equipment	☐	Employee took a short cut.
☐	Wrong equipment/tool was used for the task at hand.	☐	Employee failed to warn or signal the hazard.
☐	The equipment/tool used was not inspected/maintained properly.	☐	Employee failed to secure or tie down materials to prevent unexpected movement.
☐	The equipment/tool was faulty or defective.	☐	The unsafe act was conducted by someone other than the injured employee.
☐	Required safety devices were inadequate/defective.		**Repetitive/Forceful/Awkward Work**
☐	Required safety devices were disabled/removed.	☐	The workstation design or layout was not proper.
	Unsafe Condition/Exposure	☐	Employee was lifting awkward-shaped items.
☐	There was an extreme temperature (hot or cold) or weather condition.	☐	The task required excessive use of finger or hand.
☐	There were hazardous environmental conditions, e.g., gas, smoke, dust, fumes, mold.	☐	Employee was reaching too far.
☐	There was a fire and explosion hazard.	☐	Employee was using computer more than two to four hours a day at work.
☐	The ventilation was not adequate.	☐	Employee's task required awkward posture – bending, twisting, and/or stooping.
☐	The environment was noisy.	☐	Employee was improperly lifting, pushing and/or pulling.
☐	There was poor housekeeping.	☐	Employee was experiencing pain and discomfort.
☐	There was presence of insect and/or animal.		**Exercise/Fitness/Drill**
☐	There was exposure to pathogen, bacteria, infection, etc.	☐	The fitness or exercise area was not designed appropriately.
☐	There was a slip, trip, and fall hazard.	☐	Employee was training too hard or too often without having sufficient rest between workouts/fitness activities.
☐	There were no handrails, guardrails and/or fall protection available or used.	☐	Employee did not take time to stretch/warm up appropriately.
☐	There was poor visibility or insufficient lighting.	☐	Employee did not know their body's physical condition and/or limitations.
☐	There was inadequate warning system (labels, signs, alarm, etc.) to identify unsafe condition and/or hazard.	☐	Employee did not hydrate properly.
☐	There was improper storage of hazardous substances/chemicals.	☐	Employee was not wearing proper attire or equipment for the Exercise/Fitness/Drill.
☐	The area was congested or restricted.		**Failure to Follow Policy/Procedures**
☐	There was water intrusion/ leak.	☐	There was no policy or procedure for the task.
☐	There was overhead or head bump hazard.	☐	The policy or procedure related to the task was not followed properly.
☐	**Stress/Personal Factors**	☐	The policy or procedure followed was not appropriate for the task.
☐	Employee reported stress.	☐	Disciplinary action/policy was not enforced for safety infraction.
☐	Employee was disciplined or going through an investigation.	☐	There was inadequate jobsite supervision.
☐	Employee was having job performance issues.		

NEAR-MISS REPORTING AND INVESTIGATION FORM

Note: A **Near-Miss** is an unplanned event that did not result in an injury and/or illness but had the potential to do so.

Name of the employee completing this form:

☐ Supervisor ☐ Safety Representative ☐ Witness ☐ Other If other, please indicate job title:	Contact Phone Number:
Date of the Near-Miss event:	Time of the Near-Miss: _____ ☐ a.m. ☐ p.m.
Location where the Near-Miss event occurred: Address: Area:	
Supervision at time of accident: ☐ Directly supervised ☐ Indirectly supervised ☐ Not supervised ☐ Supervision not feasible	Employee was working: ☐ Alone ☐ With crew or fellow worker ☐ Other If other, specify:

Description of the Near-Miss event. Please explain the following: 1) **Who** was involved in the Near-Miss 2) **What** exactly happened **3**) **How** did the Near-Miss occur (Include photos and diagram and use additional sheet if necessary)

Were there unsafe acts that contributed to this Near-Miss event? ☐ Yes ☐ No

If "Yes", check all that apply below.

- ☐ Lack of training or skill
- ☐ Lack of written procedure
- ☐ Inadequate procedure
- ☐ Failure to anticipate
- ☐ Disabled safety devices
- ☐ Operating at unsafe speeds
- ☐ Operating without proper authority
- ☐ Working on moving equipment
- ☐ Improper personal protective equipment (PPE)
- ☐ Failure to lockout
- ☐ Horseplay
- ☐ Unsafe lifting
- ☐ Improper attire
- ☐ Poor housekeeping
- ☐ Distracted
- ☐ Rushed
- ☐ Failure to use available equipment or tools
- ☐ Other, specify_____

Were there unsafe conditions that contributed to this Near-Miss event? ☐ Yes ☐ No

If "Yes", check all that apply below.

- ☐ Inadequate guarding
- ☐ Unsafe equipment
- ☐ Defective equipment or tools
- ☐ Improper lighting
- ☐ Improper ventilation
- ☐ Unsafe position/ergonomic issue
- ☐ Weather conditions - snow and ice
- ☐ Uneven walking surface
- ☐ Slippery walking surface
- ☐ Noise
- ☐ Other, specify_____

What actions have or will be taken to prevent similar incident/event?

Who is responsible for taking these actions and following up to see that they are complete (Name/Title)?

Expected completion date:	Actual completion date:
Signature:	Date: