

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:		OSHA CASE NO.						
				FATALITY <input type="checkbox"/>						
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		Please do not use this column				
	2. MAILING ADDRESS: (Number, Street, City, Zip)			2a. Phone Number			CASE NUMBER			
	3. LOCATION if different from Mailing Address (Number, Street, City and Zip)			3a. Location Code		OWNERSHIP				
	4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.			5. State unemployment insurance acct.no						
	6. TYPE OF EMPLOYER: Private State County City School District <input type="checkbox"/> Other Gov't, Specify: _____					INDUSTRY				
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)		OCCUPATION	
	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)		SEX	
	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							AGE		
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)			20a. COUNTY		21. ON EMPLOYER'S PREMISES? Yes No		DAILY HOURS		
	22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.				23. Other Workers injured or ill in this event? Yes No				DAYS PER WEEK	
	24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold							WEEKLY HOURS		
	25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.							WEEKLY WAGE		
	26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, 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							COUNTY		
								NATURE OF INJURY		
							PART OF BODY			
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*.							SOURCE			
							EVENT			
							SECONDARY SOURCE			
EMPLOYEE	35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)									
	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 WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? Yes No		EXTENT OF INJURY				
Completed By (type or print)			Signature & Title				Date (mm/dd/yy)			
* 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: <input type="checkbox"/> M <input type="checkbox"/> 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: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	Have you been treated by a physician for this injury/illness before? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No External job site: <input type="checkbox"/> Yes <input type="checkbox"/> No	Time of accident/incident: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> 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: <input type="checkbox"/> Property Damage <input type="checkbox"/> First Aid <input type="checkbox"/> Injury/Illness Requiring Medical Treatment <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>	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 <input type="checkbox"/> Regular Duty <input type="checkbox"/> 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).			
<input type="checkbox"/> Lack of Knowledge/Skill/Training	<input type="checkbox"/> Failure to Follow Policy/Procedures	<input type="checkbox"/> Stress/Personal Factors	
<input type="checkbox"/> Unsafe Use of Tools/Equipment	<input type="checkbox"/> Unsafe Act	<input type="checkbox"/> Repetitive/Forceful/Awkward Work	
<input type="checkbox"/> Unsafe Condition/Exposure	<input type="checkbox"/> Exercise/Fitness/Drill	<input type="checkbox"/> Use of Force (For Sworn Only)	
<input type="checkbox"/> Traffic Accident (Fill out Form Gen. 88, Automobile Accident Report)			
What is the chance of this accident/incident happening again? <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, date reported:	
Is modified duty available? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/>	Employee had difficulty interacting with co-workers and/or supervisor.
<input type="checkbox"/>	Incident occurred due to inadequate knowledge/skill.		Unsafe Act
<input type="checkbox"/>	Training was not available/provided for the associated task.	<input type="checkbox"/>	Employee was operating equipment at an improper speed/capacity.
<input type="checkbox"/>	Employee reported inadequate understanding of training materials.	<input type="checkbox"/>	Employee was involved in horseplay.
<input type="checkbox"/>	Employee was not trained to perform the task.	<input type="checkbox"/>	Employee was not using proper personal protective equipment (PPE).
<input type="checkbox"/>	New work methods were introduced without training.	<input type="checkbox"/>	Employee was in a rush.
<input type="checkbox"/>	Employee did not attend the required refresher training.	<input type="checkbox"/>	Employee failed to use available equipment.
	Unsafe Use of Tools/Equipment	<input type="checkbox"/>	Employee took a short cut.
<input type="checkbox"/>	Wrong equipment/tool was used for the task at hand.	<input type="checkbox"/>	Employee failed to warn or signal the hazard.
<input type="checkbox"/>	The equipment/tool used was not inspected/maintained properly.	<input type="checkbox"/>	Employee failed to secure or tie down materials to prevent unexpected movement.
<input type="checkbox"/>	The equipment/tool was faulty or defective.	<input type="checkbox"/>	The unsafe act was conducted by someone other than the injured employee.
<input type="checkbox"/>	Required safety devices were inadequate/defective.		Repetitive/Forceful/Awkward Work
<input type="checkbox"/>	Required safety devices were disabled/removed.	<input type="checkbox"/>	The workstation design or layout was not proper.
	Unsafe Condition/Exposure	<input type="checkbox"/>	Employee was lifting awkward-shaped items.
<input type="checkbox"/>	There was an extreme temperature (hot or cold) or weather condition.	<input type="checkbox"/>	The task required excessive use of finger or hand.
<input type="checkbox"/>	There were hazardous environmental conditions, e.g., gas, smoke, dust, fumes, mold.	<input type="checkbox"/>	Employee was reaching too far.
<input type="checkbox"/>	There was a fire and explosion hazard.	<input type="checkbox"/>	Employee was using computer more than two to four hours a day at work.
<input type="checkbox"/>	The ventilation was not adequate.	<input type="checkbox"/>	Employee's task required awkward posture – bending, twisting, and/or stooping.
<input type="checkbox"/>	The environment was noisy.	<input type="checkbox"/>	Employee was improperly lifting, pushing and/or pulling.
<input type="checkbox"/>	There was poor housekeeping.	<input type="checkbox"/>	Employee was experiencing pain and discomfort.
<input type="checkbox"/>	There was presence of insect and/or animal.		Exercise/Fitness/Drill
<input type="checkbox"/>	There was exposure to pathogen, bacteria, infection, etc.	<input type="checkbox"/>	The fitness or exercise area was not designed appropriately.
<input type="checkbox"/>	There was a slip, trip, and fall hazard.	<input type="checkbox"/>	Employee was training too hard or too often without having sufficient rest between workouts/fitness activities.
<input type="checkbox"/>	There were no handrails, guardrails and/or fall protection available or used.	<input type="checkbox"/>	Employee did not take time to stretch/warm up appropriately.
<input type="checkbox"/>	There was poor visibility or insufficient lighting.	<input type="checkbox"/>	Employee did not know their body's physical condition and/or limitations.
<input type="checkbox"/>	There was inadequate warning system (labels, signs, alarm, etc.) to identify unsafe condition and/or hazard.	<input type="checkbox"/>	Employee did not hydrate properly.
<input type="checkbox"/>	There was improper storage of hazardous substances/chemicals.	<input type="checkbox"/>	Employee was not wearing proper attire or equipment for the Exercise/Fitness/Drill.
<input type="checkbox"/>	The area was congested or restricted.		Failure to Follow Policy/Procedures
<input type="checkbox"/>	There was water intrusion/ leak.	<input type="checkbox"/>	There was no policy or procedure for the task.
<input type="checkbox"/>	There was overhead or head bump hazard.	<input type="checkbox"/>	The policy or procedure related to the task was not followed properly.
	Stress/Personal Factors	<input type="checkbox"/>	The policy or procedure followed was not appropriate for the task.
<input type="checkbox"/>	Employee reported stress.	<input type="checkbox"/>	Disciplinary action/policy was not enforced for safety infraction.
<input type="checkbox"/>	Employee was disciplined or going through an investigation.	<input type="checkbox"/>	There was inadequate jobsite supervision.
<input type="checkbox"/>	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:

Date of the Near-Miss event:

Contact Phone Number:

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.

- | | |
|---|--|
| <input type="checkbox"/> Lack of training or skill | <input type="checkbox"/> Failure to lockout |
| <input type="checkbox"/> Lack of written procedure | <input type="checkbox"/> Horseplay |
| <input type="checkbox"/> Inadequate procedure | <input type="checkbox"/> Unsafe lifting |
| <input type="checkbox"/> Failure to anticipate | <input type="checkbox"/> Improper attire |
| <input type="checkbox"/> Disabled safety devices | <input type="checkbox"/> Poor housekeeping |
| <input type="checkbox"/> Operating at unsafe speeds | <input type="checkbox"/> Distracted |
| <input type="checkbox"/> Operating without proper authority | <input type="checkbox"/> Rushed |
| <input type="checkbox"/> Working on moving equipment | <input type="checkbox"/> Failure to use available equipment or tools |
| <input type="checkbox"/> Improper personal protective equipment (PPE) | <input type="checkbox"/> Other, specify _____ |

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

If "Yes", check all that apply below.

- | |
|--|
| <input type="checkbox"/> Inadequate guarding |
| <input type="checkbox"/> Unsafe equipment |
| <input type="checkbox"/> Defective equipment or tools |
| <input type="checkbox"/> Improper lighting |
| <input type="checkbox"/> Improper ventilation |
| <input type="checkbox"/> Unsafe position/ergonomic issue |
| <input type="checkbox"/> Weather conditions - snow and ice |
| <input type="checkbox"/> Uneven walking surface |
| <input type="checkbox"/> Slippery walking surface |
| <input type="checkbox"/> Noise |
| <input type="checkbox"/> 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:

Signature:

Actual completion date:

Date: