

**OFFICE OF RISK MANAGEMENT  
UNIT OF RISK ANALYSIS AND LOSS PREVENTION  
INCIDENT/ACCIDENT INVESTIGATION FORM**

PLEASE TYPE OR PRINT

1. LOCATION CODE \_\_\_\_\_ 2. ACCIDENT DATE \_\_\_\_\_ 3. REPORTING DATE \_\_\_\_\_

4. JOB TITLE \_\_\_\_\_ 5. IMMEDIATE SUPERVISOR \_\_\_\_\_

6. EMPLOYEE'S NAME (LAST-FIRST) \_\_\_\_\_ 7. SOCIAL SECURITY # \_\_\_\_\_

8. DESCRIBE IN DETAIL HOW INCIDENT/ACCIDENT OCCURRED (USE ADDITIONAL SHEETS IF NECESSARY) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

EMPLOYEE'S SIGNATURE \_\_\_\_\_

9. NAME OF PERSON FILLING OUT REPORT \_\_\_\_\_ SIGNATURE \_\_\_\_\_

10. AGENCY \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

11. PARISH WHERE OCCURRED \_\_\_\_\_ PARISH OF DOMICILE \_\_\_\_\_

12. WAS MEDICAL TREATMENT REQUIRED \_\_\_Y\_\_\_N 13. WAS EQUIPMENT INVOLVED \_\_\_Y\_\_\_N \_\_\_\_\_

14. HAVE SIMILAR ACCIDENT/INCIDENTS OCCURRED \_\_\_Y\_\_\_N 15. INVOLVING SAME INDIVIDUAL \_\_\_Y\_\_\_N 16. SAME LOCATION \_\_\_Y\_\_\_N

17. EXACT LOCATION WHERE EVENT OCCURRED \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

18. NAME (S) OF WITNESSES \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CAUSE CODE**

<input type="checkbox"/> AA AUTO ACCIDENT <input type="checkbox"/> AB CONTACT WITH SKIN IRRITANT <input type="checkbox"/> AC INSECT BITE OR STING <input type="checkbox"/> AD POISONING <input type="checkbox"/> AE EXTREME NOISE <input type="checkbox"/> AF ANIMAL BITE <input type="checkbox"/> AG OVEREXERTION <input type="checkbox"/> AH STROKE <input type="checkbox"/> AI HEART ATTACK <input type="checkbox"/> AJ MENTAL STRESS <input type="checkbox"/> AK TRAUMATIC NEUROSIS <input type="checkbox"/> AL EXPOSURE TO OCCUPATIONAL DISEASE <input type="checkbox"/> AM INHALATION OF CHEMICALS/OTHER IRRITANTS <input type="checkbox"/> AN FOREIGN BODY IN EYE <input type="checkbox"/> AR HUMAN BITE <input type="checkbox"/> 1A STRUCK BY MOVING OBJECT OTHER THAN A VEHICLE <input type="checkbox"/> 1B STRUCK BY MOTOR VEHICLE	<input type="checkbox"/> 1C STRUCK BY PATIENT OR EMPLOYEE <input type="checkbox"/> 2A STRAIN BY LIFTING, TWISTING, OR USING TOOL/MACH <input type="checkbox"/> 3A SLIP AND FALL ON FOREIGN OBJECT <input type="checkbox"/> 3B SLIP AND FALL FROM LADDERS, SCAFFOLDING, & CHAIRS <input type="checkbox"/> 3C SLIP AND FALL FROM RAMPS, CURBING, OR STAIRS <input type="checkbox"/> 4A STRIKING AGAINST OBJECT <input type="checkbox"/> 5A STEPPING ON A SHARP OBJECT <input type="checkbox"/> 6A CAUGHT IN / BETWEEN MACHINERY OR OTHER OBJECTS <input type="checkbox"/> 7A BURN OR EXPOSURE DUE TO PHYSICAL CONTACT <input type="checkbox"/> 7B BURN OR EXPOSURE INVOLVING WELDING <input type="checkbox"/> 7C BURN OR EXPOSURE TO EXTREME HEAT OR COLD <input type="checkbox"/> 7D BURN OR EXPOSURE INVOLVING CHEMICALS <input type="checkbox"/> 7E BURN OR EXPOSURE INVOLVING ELECTRICITY <input type="checkbox"/> 8A CUT, PUNCTURE OR SCRAPE BY A TOOL <input type="checkbox"/> 8B CUT, PUNCTURE OR SCRAPE INVOLVING GLASS <input type="checkbox"/> 8C CUT, PUNCTURE OR SCRAPE BY A SHARP OBJECT <input type="checkbox"/> 9A TRIPPING
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FIELD 23—CITY	FIELD 27—DAY OF WEEK	FIELD 28—TIME OF DAY		
<input type="checkbox"/> A NEW ORLEANS	<input type="checkbox"/> 1 SUNDAY	<input type="checkbox"/> A 12:01AM-1:00AM	<input type="checkbox"/> J 9:01AM-10:00AM	<input type="checkbox"/> S 6:01PM- 7:00PM
<input type="checkbox"/> B BATON ROUGE	<input type="checkbox"/> 2 MONDAY	<input type="checkbox"/> B 1:01AM-2:00AM	<input type="checkbox"/> K 10:01AM-10:00AM	<input type="checkbox"/> T 7:01PM- 8:00PM
<input type="checkbox"/> C LAKE CHARLES	<input type="checkbox"/> 3 TUESDAY	<input type="checkbox"/> C 2:01AM-3:00AM	<input type="checkbox"/> L 11:01AM-12:00PM	<input type="checkbox"/> U 8:01PM- 9:00PM
<input type="checkbox"/> D SHREVEPORT	<input type="checkbox"/> 4 WEDNESDAY	<input type="checkbox"/> D 3:01AM-4:00AM	<input type="checkbox"/> M 12:01PM- 1:00PM	<input type="checkbox"/> V 9:01PM-10:00PM
<input type="checkbox"/> E ALEXANDRIA	<input type="checkbox"/> 5 THURSDAY	<input type="checkbox"/> E 4:01AM-5:00AM	<input type="checkbox"/> N 1:01PM- 2:00PM	<input type="checkbox"/> W 10:01PM-11:00PM
<input type="checkbox"/> F LAFAYETTE	<input type="checkbox"/> 6 FRIDAY	<input type="checkbox"/> F 5:01AM-6:00AM	<input type="checkbox"/> O 2:01PM- 3:00PM	<input type="checkbox"/> X 11:01PM-12:00AM
<input type="checkbox"/> G MONROE	<input type="checkbox"/> 7 SATURDAY	<input type="checkbox"/> G 6:01AM-7:00AM	<input type="checkbox"/> P 3:01PM- 4:00PM	
<input type="checkbox"/> Z CITY NOT LISTED		<input type="checkbox"/> H 7:01AM-8:00AM	<input type="checkbox"/> Q 4:01PM- 5:00PM	<b>FIELD 36—NEED LOSS PREVENTION OFFICER ASSISTANCE ___Y___N</b>
<input type="checkbox"/> O RURAL AREA		<input type="checkbox"/> I 8:01AM-9:00AM	<input type="checkbox"/> R 5:01PM- 6:00PM	
<input type="checkbox"/> I INTERNATIONAL				

**FIELD 41—NATURE OF INJURY**

AA AMPUTATION  
 AB ANIMAL BITE  
 AC BRUISE/CONTUSION/SWELLING  
 AD BURN/ABRASION/REDNESS  
 AE CONCUSSION  
 AF DEATH  
 AG DEPRESSION AND ANXIETY  
 AH DERMATITIS  
 AI DISLOCATION OR SEPARATION  
 AJ ELECTRICAL SHOCK OR BURN

AK EYE IRRITATION/DAMAGE  
 AL FRACTURE  
 AM HEARING IMPAIRMENT  
 AN HEART ATTACK  
 AP HEAT STROKE  
 AQ HERNIA  
 AR HERNIATED DISC  
 AS INSECT BITE/STING  
 AT LACERATION  
 AU LOSS OF VISION

AV SMASHED OR CRUSHED  
 AW MENTAL ANGUISH  
 AX MULTIPLE INJURIES  
 AY POISONING  
 AZ PUNCTURE  
 BA PROSTHETIC REPLACEMENT  
 BB SEIZURE  
 BC SPRAIN/STRAIN  
 BD STRESS  
 BE STROKE  
 HB HUMAN BITE

**FIELD 43-SEX OF EMPLOYEE**

FEMALE  
 MALE

**FIELD 44-LENGTH OF SERVICE**

0 LESS THAN 6 MOS.  
 1 7 MOS.-1 YEAR  
 2 1-3 YEARS  
 3 3-5 YEARS  
 4 5-10 YEARS  
 5 10-15 YEARS  
 6 MORE THAN 15 YEARS

**FIELD 43-AGE OF EMPLOYEE**

A 15-17       H 51-55  
 B 18-21       I 56-60  
 C 22-25       J 61-65  
 D 26-30       K OVER 65  
 E 31-35  
 F 36-40  
 G 41-50

**FIELD 50- PART OF BODY**

AA HEAD  
 AG JAW  
 BB BACK  
 BH GROIN  
 CC ELBOW  
 DB THIGH  
 DH TOE

AB FOREHEAD  
 AH TEETH  
 BC CHEST  
 BI GENITAL  
 CD WRIST  
 DC KNEE  
 BK SPINE

AC EYE  
 AI FACE  
 BD RIBS  
 BJ BUTTOCK  
 CE HAND  
 DD LEG  
 DE SKIN

AD EAR  
 AJ CHEEK  
 BE STOMACH  
 BL INTERNAL  
 CF THUMB  
 DF ANKLE

AE NOSE  
 AK THROAT  
 BF LUNGS  
 CA SHOULDER  
 CG FINGER  
 DG FOOT

AF MOUTH  
 BA NECK  
 BG HEART  
 CB ARM  
 DA HIP

**ROOT CAUSE ANALYSIS PORTION**

*UNSAFE ACT (PRIMARY):*

*UNSAFE CONDITION (PRIMARY):*

*CONTRIBUTORY FACTORS (IF ANY):*

*WHY WAS ACT COMMITTED:*

*WHY DID CONDITION EXIST:*

*IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:*

*LONG RANGE ACTION TO BE TAKEN:*

*WHAT ADDITIONAL ASSISTANCE IS NEEDED TO PREVENT RECURRENCE:*

**KEEP COMPLETED FORMS ON FILE FOR ALL INCIDENTS OR ACCIDENTS.**