

**STATE EMPLOYEE INCIDENT/ACCIDENT ANALYSIS FORM - DA2000**

OFFICE OF RISK MANAGEMENT - UNIT OF RISK ANALYSIS AND LOSS PREVENTION

**WORKER'S COMPENSATION – FOR AGENCY USE ONLY**

- This form is NOT for use in reporting a claim. The claim reporting form can be found at: [www.laorm.com](http://www.laorm.com)
- Required for all incidents/accidents except auto accidents, for which a police report serves as the investigation document.
- Keep completed forms on file at the location where the audit/compliance review will occur.

(PLEASE TYPE OR PRINT)

1. AGENCY NAME and LOCATION CODE: ULM 5080

2. ACCIDENT DATE and TIME: \_\_\_\_\_ 3. REPORTING DATE: \_\_\_\_\_

4. EMPLOYEE NAME (LAST, FIRST): \_\_\_\_\_

5. JOB TITLE: \_\_\_\_\_

6. IMMEDIATE SUPERVISOR: \_\_\_\_\_

7. DESCRIBE IN DETAIL HOW INCIDENT/ACCIDENT OCCURRED: (USE ADDITIONAL SHEET IF NECESSARY): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. PARISH WHERE OCCURRED: \_\_\_\_\_ 9. PARISH OF DOMICILE: \_\_\_\_\_

10. WAS MEDICAL TREATMENT REQUIRED?     Y    N?

11. EXACT LOCATION WHERE EVENT OCCURRED: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

12. NAME(S) OF WITNESS(ES): \_\_\_\_\_

13. NAME OF PERSON COMPLETING THIS SECTION OF REPORT: \_\_\_\_\_

14. SIGNATURE: \_\_\_\_\_ 15. DATE: \_\_\_\_\_

**This form is for internal use only  
and is prepared in anticipation of litigation.**

# STATE EMPLOYEE INCIDENT/ACCIDENT INVESTIGATION FORM – DA2000

## MANAGEMENT SECTION

16. NAME OF PERSON COMPLETING THIS SECTION OF REPORT: \_\_\_\_\_
17. POSITION/TITLE: \_\_\_\_\_
18. IS THE PERSON COMPLETING REPORT TRAINED IN ACCIDENT INVESTIGATION? \_\_\_\_\_ Y \_\_\_\_\_ N
19. WAS EQUIPMENT INVOLVED? \_\_\_\_\_ Y \_\_\_\_\_ N (If no, skip to question 20) STATE-OWNED? \_\_\_\_\_ Y \_\_\_\_\_ N
- A. TYPE OF EQUIPMENT: \_\_\_\_\_
- B. IS THERE A JSA FOR EQUIPMENT? \_\_\_\_\_ Y \_\_\_\_\_ N C. DATE LAST JSA PERFORMED: \_\_\_\_\_
- D. MOST RECENT DATE AFFECTED EMPLOYEE RECEIVED TRAINING ON THE JSA: \_\_\_\_\_
20. HAVE SIMILAR ACCIDENT/INCIDENTS OCCURRED? \_\_\_\_\_ Y \_\_\_\_\_ N
21. DID INCIDENT INVOLVE SAME INDIVIDUAL? \_\_\_\_\_ Y \_\_\_\_\_ N 22. SAME LOCATION? \_\_\_\_\_ Y \_\_\_\_\_ N
23. WAS THE SCENE VISITED DURING THE INVESTIGATION? \_\_\_\_\_ Y \_\_\_\_\_ N
- A. DATE & TIME: \_\_\_\_\_ B. ARE PICTURES/VIDEO AVAILABLE? \_\_\_\_\_ Y \_\_\_\_\_ N
- C. IF NO, REASON FOR NOT VISITING: \_\_\_\_\_

### ROOT CAUSE ANALYSIS

**UNSAFE ACT (PRIMARY):**  Failure to comply with policies/procedures  Failure to use appropriate equipment/technique  Inattentiveness  
 Inadequate/lack of JSA/standards  Incomplete or no policies/procedures  Inadequate training on policies/procedures  Inadequate adherence of policies/procedures

Other (specify) \_\_\_\_\_

Detailed explanation of checked box \_\_\_\_\_

WHY WAS ACT COMMITTED:

**UNSAFE CONDITION (PRIMARY):**  Inappropriate equip/tool  Inadequate maintenance  Inadequate training  Wet surface  
 Worn/broken/defective building components  Broken equipment  Inadequate guard  Electrical hazard  Fire Hazard

Other (specify) \_\_\_\_\_

Detailed explanation of checked box \_\_\_\_\_

WHY DID CONDITION EXIST:

CONTRIBUTORY FACTORS (IF ANY):

IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:

LONG RANGE ACTION TO BE TAKEN:

WHAT ADDITIONAL ASSISTANCE IS NEEDED TO PREVENT RECURRENCE: