

<i>(For safety staff only)</i>	REPORT NO.	EROC CODE	UNITED STATES ARMY CORPS OF ENGINEERS ACCIDENT INVESTIGATION REPORT For use of this form, see Help Menu and USACE Supplement to AR 385-40 The proponent agency is CESO	REQUIREMENT CONTROL SYMBOL: CEEC-S-8 (R2)
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1. ACCIDENT CLASSIFICATION					
PERSONNEL CLASSIFICATION	INJURY/ILLNESS/FATAL	PROPERTY DAMAGE		MOTOR VEHICLE INVOLVED	DIVING
GOVERNMENT <input type="checkbox"/> CIVILIAN <input type="checkbox"/> MILITARY	<input type="checkbox"/>	<input type="checkbox"/> FIRE INVOLVED	<input type="checkbox"/> OTHER	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> CONTRACTOR	<input type="checkbox"/>	<input type="checkbox"/> FIRE INVOLVED	<input type="checkbox"/> OTHER	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PUBLIC	<input type="checkbox"/> FATAL <input type="checkbox"/> OTHER	PROPERTY DAMAGE		<input type="checkbox"/>	DIVING

2. PERSONAL DATA				
a. NAME (Last, First MI.)	b. AGE	c. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	d. SOCIAL SECURITY NUMBER	e. GRADE
f. JOB SERIES/TITLE	g. DUTY STATUS AT TIME OF ACCIDENT <input type="checkbox"/> ON DUTY <input type="checkbox"/> TDY <input type="checkbox"/> OFF DUTY		h. EMPLOYMENT STATUS AT TIME OF ACCIDENT <input type="checkbox"/> ARMY ACTIVE <input type="checkbox"/> ARMY RESERVE <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> PERMANENT <input type="checkbox"/> FOREIGN NATIONAL <input type="checkbox"/> SEASONAL <input type="checkbox"/> TEMPORARY <input type="checkbox"/> STUDENT <input type="checkbox"/> OTHER (Specify) _____	

3. GENERAL INFORMATION			
a. DATE OF ACCIDENT (YYYYMMDD)	b. TIME OF ACCIDENT (Military Time) hrs.	c. EXACT LOCATION OF ACCIDENT	d. CONTRACTOR'S NAME (1) PRIME
e. CONTRACT NUMBER <input type="checkbox"/> CIVIL WORKS <input type="checkbox"/> MILITARY <input type="checkbox"/> OTHER (Specify) _____		f. TYPE OF CONTRACT <input type="checkbox"/> CONSTRUCTION <input type="checkbox"/> SERVICE <input type="checkbox"/> A/E <input type="checkbox"/> DREDGE <input type="checkbox"/> OTHER (Specify) _____	g. HAZARDOUS/TOXIC WASTE ACTIVITY <input type="checkbox"/> SUPERFUND <input type="checkbox"/> DERP <input type="checkbox"/> IRP <input type="checkbox"/> OTHER (Specify) _____ (2) SUBCONTRACTOR

4. CONSTRUCTION ACTIVITIES ONLY (Fill in line and corresponding code number in box from list - see help menu)	
a. CONSTRUCTION ACTIVITY (CODE) # <input style="width:50px;" type="text"/>	b. TYPE OF CONSTRUCTION EQUIPMENT (CODE) # <input style="width:50px;" type="text"/>

5. INJURY/ILLNESS INFORMATION (Include name on line and corresponding code number in box for items e, f & g - see help menu)			
a. SEVERITY OF ILLNESS/INJURY (CODE) # <input style="width:50px;" type="text"/>	b. ESTIMATED DAYS LOST	c. ESTIMATED DAYS HOSPITALIZED	d. ESTIMATED DAYS RESTRICTED DUTY
e. BODY PART AFFECTED (CODE) PRIMARY # <input style="width:50px;" type="text"/> (CODE) SECONDARY # <input style="width:50px;" type="text"/>	g. TYPE AND SOURCE OF INJURY/ILLNESS (CODE) TYPE # <input style="width:50px;" type="text"/> (CODE) SOURCE # <input style="width:50px;" type="text"/>		
f. NATURE OF ILLNESS / INJURY (CODE) # <input style="width:50px;" type="text"/>			

6. PUBLIC FATALITY (Fill in line and correspondence code number in box - see help menu)	
a. ACTIVITY AT TIME OF ACCIDENT (CODE) # <input style="width:50px;" type="text"/>	b. PERSONAL FLOTATION DEVICE USED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

7. MOTOR VEHICLE ACCIDENT							
a. TYPE OF VEHICLE		b. TYPE OF COLLISION		c. SEAT BELTS	USED	NOT USED	NOT APPLICABLE
<input type="checkbox"/> <input type="checkbox"/> PICKUP/VAN <input type="checkbox"/> <input type="checkbox"/> AUTOMOBILE <input type="checkbox"/> <input type="checkbox"/> TRUCK <input type="checkbox"/> <input type="checkbox"/> OTHER (Specify) _____		<input type="checkbox"/> SIDE SWIPE <input type="checkbox"/> HEAD ON <input type="checkbox"/> REAR END <input type="checkbox"/> BROADSIDE <input type="checkbox"/> ROLL OVER <input type="checkbox"/> BACKING <input type="checkbox"/> OTHER (Specify) _____		(1) FRONT SEAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				(2) REAR SEAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. PROPERTY MATERIAL INVOLVED							
a. NAME OF ITEM			b. OWNERSHIP		c. AMOUNT OF DAMAGE		
(1)							
(2)							
(3)							
9. VESSEL/FLOATING PLANT ACCIDENT (Fill in line and correspondence code number in box from list - see help menu)							
a. ACTIVITY AT TIME OF ACCIDENT			(CODE)	a. ACTIVITY AT TIME OF ACCIDENT		(CODE)	
_____ # <input type="text"/>				_____ # <input type="text"/>			
10. ACCIDENT DESCRIPTION (Use additional paper, if necessary, see attached page 4.)							
11. CAUSAL FACTOR(s) (Read instructions before completing)							
a. (Explain YES answers in item 13)							
DESIGN: Was design of facility, workplace or equipment a factor?					YES	NO	
INSPECTION/MAINTENANCE: Were inspection & maintenance procedures a factor?					<input type="checkbox"/>	<input type="checkbox"/>	
PERSON'S PHYSICAL CONDITION: In your opinion, was the physical condition of the person a factor?					<input type="checkbox"/>	<input type="checkbox"/>	
OPERATING PROCEDURES: Were operating procedures a factor?					<input type="checkbox"/>	<input type="checkbox"/>	
JOB PRACTICES: Were any job safety/health practices not followed when the accident occurred?					<input type="checkbox"/>	<input type="checkbox"/>	
HUMAN FACTORS: Did any human factors such as, size or strength of person, etc., contribute to accident?					<input type="checkbox"/>	<input type="checkbox"/>	
ENVIRONMENTAL FACTORS: Did heat, cold, dust, sun, glare, etc., contribute to the accident?					<input type="checkbox"/>	<input type="checkbox"/>	
CHEMICAL AND PHYSICAL AGENT FACTORS: Did exposure to chemical agents, such as dust, fumes, mists, vapors or physical agents, such as, noise, radiation, etc., contribute to accident?					<input type="checkbox"/>	<input type="checkbox"/>	
OFFICE FACTORS: Did office setting such as, lifting office furniture, carrying, stooping, etc., contribute to the accident?					<input type="checkbox"/>	<input type="checkbox"/>	
SUPPORT FACTORS: Were inappropriate tools/resources provided to properly perform the activity/task?					<input type="checkbox"/>	<input type="checkbox"/>	
PERSONAL PROTECTIVE EQUIPMENT: Did the improper selection, use or maintenance of personal protective equipment contribute to the accident?					<input type="checkbox"/>	<input type="checkbox"/>	
DRUGS/ALCOHOL: In your opinion, was drugs or alcohol a factor to the accident?					<input type="checkbox"/>	<input type="checkbox"/>	
b. WAS A WRITTEN JOB/ACTIVITY HAZARD ANALYSIS COMPLETED FOR TASK BEING PERFORMED AT TIME OF ACCIDENT? (If yes, attach a copy.)					<input type="checkbox"/>	<input type="checkbox"/>	
12. TRAINING							
a. WAS PERSON TRAINED TO PERFORM ACTIVITY/TASK?			b. TYPE OF TRAINING		c. DATE OF MOST RECENT FORMAL TRAINING (YYYYMMDD)		
<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> CLASSROOM <input type="checkbox"/> ON JOB				
13. FULLY EXPLAIN WHAT ALLOWED OR CAUSED THE ACCIDENT; INCLUDE DIRECT AND INDIRECT CAUSES (See instruction for definition of direct and indirect causes.) (Use additional paper, if necessary)							
a. DIRECT CAUSE(s) (Attach additional sheets as needed, See page 4)							
b. INDIRECT CAUSE(s) (Attach additional sheets as needed, See page 5)							

14. ACTION(s) TAKEN, ANTICIPATED OR RECOMMENDED TO ELIMINATE CAUSE(s)		
DESCRIBE FULLY <i>(Attach additional sheets as necessary, See page 5)</i>		
15. DATES FOR ACTIONS IDENTIFIED IN BLOCK 14.		
a. BEGINNING (YYYYMMDD)		b. ANTICIPATED COMPLETION (YYYYMMDD)
c. DATE SIGNED (YYYYMMDD)	d. TITLE OF SUPERVISOR COMPLETING REPORT	e. CORPS SIGNATURE, SUPERVISOR COMPLETING REPORT
c. DATE SIGNED (YYYYMMDD)	d. TITLE OF SUPERVISOR COMPLETING REPORT	e. CONTRACTOR SIGNATURE, SUPERVISOR COMPLETING REPORT
f. ORGANIZATION IDENTIFIER <i>(Division, Branch, Section, etc.,)</i>		g. OFFICE SYMBOL
16. MANAGEMENT REVIEW <i>(1st)</i>		
a. <input type="checkbox"/> CONCUR b. <input type="checkbox"/> NONCONCUR c. COMMENTS		
DATE (YYYYMMDD)	TITLE	SIGNATURE
17. MANAGEMENT REVIEW <i>(2nd - Chief Operations, Construction, Engineering, etc.,)</i>		
a. <input type="checkbox"/> CONCUR b. <input type="checkbox"/> NONCONCUR c. COMMENTS		
DATE (YYYYMMDD)	TITLE	SIGNATURE
18. SAFETY AND OCCUPATIONAL HEALTH OFFICE REVIEW		
a. <input type="checkbox"/> CONCUR b. <input type="checkbox"/> NONCONCUR c. ADDITIONAL ACTIONS/COMMENTS		
DATE (YYYYMMDD)	TITLE	SIGNATURE
19. COMMAND APPROVAL		
COMMENTS		
DATE (YYYYMMDD)	COMMANDER SIGNATURE	

10.

ACCIDENT DESCRIPTION *(Continuation)*

13a.

DIRECT CAUSE(s) *(Continuation)*

13b.

INDIRECT CAUSE(s) (Continuation)

14.

ACTION(s) TAKEN, ANTICIPATED, OR RECOMMENDED TO ELIMINATE CAUSE(s) (Continuation)

GENERAL. Complete a separate report for each person who was injured, caused, or contributed to the accident (*excluding uninjured personnel and witnesses*). Use of this form for reporting USACE employee first-aid type injuries not submitted to the Office of Workers' Compensation Programs (*OWCP*) shall be at the discretion of the FOA commander. Please type or print legibly. Appropriate items shall be marked with an "X" in box(es). If additional space is needed, provide the information on a separate sheet and attach to the completed form. Ensure that these instructions are forwarded with the completed report to the designated management reviewers indicated in sections 16 and 17.

INSTRUCTIONS FOR SECTION 1 - ACCIDENT CLASSIFICATION

(Mark All Boxes That Are Applicable)

a. GOVERNMENT. Mark "CIVILIAN" box if accident involved government civilian employee; mark "MILITARY" box if accident involved U.S. military personnel.

(1) INJURY/ILLNESS/FATALITY - Mark if accident resulted in any government civilian employee injury, illness, or fatality that requires the submission of OWCP Forms CA-1 (*injury*), CA-2 (*illness*) or CA-6 (*fatality*) to OWCP; mark if accident resulted in military personnel lost-time or fatal injury or illness.

(2) PROPERTY DAMAGE - Mark the appropriate box if accident resulted in any damage of \$1000 or more to government property (*including motor vehicles*).

(3) VEHICLE INVOLVED - Mark if accident involved a motor vehicle, regardless of whether "INJURY/ILLNESS/FATALITY" or "PROPERTY DAMAGE" are marked.

(4) DIVING ACTIVITY - Mark if the accident involved an in-house USACE diving activity.

b. CONTRACTOR.

(1) INJURY/ILLNESS/FATALITY - Mark if accident resulted in any contractor lost-time injury/illness or fatality.

(2) PROPERTY DAMAGE - Mark the appropriate box if accident resulted in any damage of \$1000 or more to contractor property (*including motor vehicles*).

(3) VEHICLE INVOLVED - Mark if accident involved a motor vehicle, regardless of whether "INJURY/ILLNESS/FATALITY" or "PROPERTY DAMAGE" are marked.

(4) DIVING ACTIVITY - Mark if the accident involved a USACE Contractor diving activity.

c. PUBLIC.

(1) INJURY/ILLNESS/FATALITY - Mark if accident resulted in public fatality or permanent total disability. (*The "OTHER" box will be marked when requested by the FOA to report an unusual non-fatal public accident that could result in claims against the government or as otherwise directed by the FOA Commander*).

(2) VOID SPACE - Make no entry.

(3) VEHICLE INVOLVED - Mark if accident resulted in a fatality to a member of the public and involved a motor vehicle, regardless of whether "INJURY/ILLNESS/FATALITY" is marked.

(4) VOID SPACE - Make no entry.

INSTRUCTIONS FOR SECTION 2 - PERSONAL DATA

a. NAME - (*MANDATORY FOR GOVERNMENT ACCIDENTS. OPTIONAL AT THE DISCRETION OF THE FOA COMMANDER FOR CONTRACTOR AND PUBLIC ACCIDENTS*). Enter last name, first name, middle initial of person involved.

b. AGE - Enter age.

c. SEX - Mark appropriate box.

d. SOCIAL SECURITY NUMBER - (*FOR GOVERNMENT PERSONNEL ONLY*) Enter the social security number (*or other personal identification number if no social security number issued*).

e. GRADE - (*FOR GOVERNMENT PERSONNEL ONLY*) Enter pay grade. Example: 0-6; E-7; WG-8; WS-12; GS-11; etc.

f. JOB SERIES/TITLE - For government civilian employees enter the pay plan, full series number, and job title, e.g., GS-O810/Civil Engineer. For military personnel enter the primary military occupational specialty (*PMOS*), e.g., 15A30 or 11G50. For contractor employees enter the job title assigned to the injured person, e.g., carpenter, laborer, surveyor, etc.

g. DUTY STATUS - Mark the appropriate box.

(1) ON DUTY - Person was at duty station during duty hours or person was away from duty station during duty hours but on official business at time of the accident.

(2) TDY - Person was on official business, away from the duty station and with travel orders at time of accident. Line-of-duty investigation required.

(3) OFF DUTY - Person was not on official business at time of accident.

h. EMPLOYMENT STATUS - (*FOR GOVERNMENT PERSONNEL ONLY*) Mark the most appropriate box. If "OTHER" is marked, specify the employment status of the person.

INSTRUCTION FOR SECTION 3 - GENERAL INFORMATION

- a. DATE OF ACCIDENT - Enter the month, day, and year of accident.
- b. TIME OF ACCIDENT - Enter the local time of accident in military time. Example: 1430 hrs (*not 2:30 p.m.*).
- c. EXACT LOCATION OF ACCIDENT - Enter facts needed to locate the accident scene, (*installation/project name, building number, street, direction and distance from closest landmark, etc.*).
- d. CONTRACTOR NAME
- (1) PRIME - Enter the exact name (*title of firm*) of the prime contractor.
- (2) SUBCONTRACTOR - Enter the name of any subcontractor involved in the accident.
- e. CONTRACT NUMBER - Mark the appropriate box to identify if contract is civil works, military, or other: if "OTHER" is marked, specify contract appropriation on line provided. Enter complete contract number of prime contract, e.g., DACW 09-85-C-0100.
- f. TYPE OF CONTRACT - Mark appropriate box. A/E means architect/engineer. If "OTHER" is marked, specify type of contract on line provided.
- g. HAZARDOUS/TOXIC WASTE ACTIVITY (*HTW*) - Mark the box to identify the HTW activity being performed at the time of the accident. For Superfund, DERP, and Installation Restoration Program (*IRP*) HTW activities include accidents that occurred during inventory, predesign, design, and construction. For the purpose of accident reporting, DERP Formerly Used DoD Site (*FUDS*) activities and IRP activities will be treated separately. For Civil Works O&M HTW activities mark the "OTHER" box.

INSTRUCTIONS FOR SECTION 4 - CONSTRUCTION ACTIVITIES

- a. CONSTRUCTION ACTIVITY - Select the most appropriate construction activity being performed at time of accident from the list below. Enter the activity name and place the corresponding code number identified in the box.

CONSTRUCTION ACTIVITY LIST

- | | |
|-------------------------|----------------------------|
| 1. MOBILIZATION | 13. CARPENTRY |
| 2. SITE PREPARATION | 14. ELECTRICAL |
| 3. EXCAVATION/TRENCHING | 15. SCAFFOLDING/ACCESS |
| 4. GRADING (EARTHWORK) | 16. MECHANICAL |
| 5. PIPING/UTILITIES | 17. PAINTING |
| 6. FOUNDATION | 18. EQUIPMENT/MAINTENANCE |
| 7. FORMING | 19. TUNNELING |
| 8. CONCRETE PLACEMENT | 20. WAREHOUSING/STORAGE |
| 9. STEEL ERECTION | 21. PAVING |
| 10. ROOFING | 22. FENCING |
| 11. FRAMING | 23. SIGNING |
| 12. MASONRY | 24. LANDSCAPING/IRRIGATION |
| | 25. INSULATION |
| | 26. DEMOLITION |

- b. TYPE OF CONSTRUCTION EQUIPMENT - Select the equipment involved in the accident from the list below. Enter the name and place the corresponding code number identified in the box. If equipment is not included below, use code 24, "OTHER", and write in specific type of equipment.

CONSTRUCTION EQUIPMENT

- | | |
|---------------------------------------------|---------------------------------------|
| 1. GRADER | 12. DUMP TRUCK (<i>HIGHWAY</i>) |
| 2. DRAGLINE | 13. DUMP TRUCK (<i>OFF HIGHWAY</i>) |
| 3. CRANE (<i>ON VESSEL/BARGE</i>) | 14. TRUCK (<i>OTHER</i>) |
| 4. CRANE (<i>TRACKED</i>) | 15. FORKLIFT |
| 5. CRANE (<i>RUBBER TIRE</i>) | 16. BACKHOE |
| 6. CRANE (<i>VEHICLE MOUNTED</i>) | 17. FRONT-END LOADER |
| 7. CRANE (<i>TOWER</i>) | 18. PILE DRIVER |
| 8. SHOVEL | 19. TRACTOR (<i>UTILITY</i>) |
| 9. SCRAPER | 20. MANLIFT |
| 10. PUMP TRUCK (<i>CONCRETE</i>) | 21. DOZER |
| 11. TRUCK (<i>CONCRETE/TRANSIT MIXER</i>) | 22. DRILL RIG |
| | 23. COMPACTOR/VIBRATORY ROLLER |
| | 24. OTHER |

INSTRUCTIONS FOR SECTION 5 - INJURY/ILLNESS INFORMATION

- a. SEVERITY OF INJURY/ILLNESS - Reference paragraph 2-10 of USACE Supplement 1 to AR 385-40 and enter code and description from list below.

- | | |
|-----|-------------------------------------------------|
| NOI | NO INJURY |
| FAT | FATALITY |
| PTL | PERMANENT TOTAL DISABILITY |
| PPR | PERMANENT PARTIAL DISABILITY |
| LWD | LOST WORKDAY CASE INVOLVING DAYS AWAY FROM WORK |
| NLW | RECORDABLE CASE WITHOUT LOST WORKDAYS |
| RFA | RECORDABLE FIRST AID CASE |
| NRI | NON-RECORDABLE INJURY |

- b. ESTIMATED DAYS LOST - Enter the estimated number of workdays the person will lose from work.

c. ESTIMATED DAYS HOSPITALIZED - Enter the estimated number of workdays the person will be hospitalized.

d. ESTIMATED DAYS RESTRICTED DUTY - Enter the estimated number of workdays the person, as a result of the accident, will not be able to perform all of their regular duties.

e. BODY PART AFFECTED - Select the most appropriate primary and when applicable, secondary body part affected from the list below. Enter body part name on line and place the corresponding code letters identifying that body part in the box.

GENERAL BODY AREA	CODE	BODY PART NAME				
ARM/WRIST	AB	ARM AND WRIST	HEAD, EXTERNAL	H1	EYE EXTERNAL	
	AS	ARM OR WRIST		H2	BOTH EYES EXTERNAL	
TRUNK, EXTERNAL MUSCULATURE	B1	SINGLE BREAST	KNEE	H3	EAR EXTERNAL	
	B2	BOTH BREASTS		H4	BOTH EARS EXTERNAL	
	B3	SINGLE TESTICLE		HC	CHIN	
	B4	BOTH TESTICLES		HF	FACE	
	BA	ABDOMEN		HK	NECK/THROAT	
	BC	CHEST		HM	MOUTH/LIPS	
	BL	LOWER BACK		HN	NOSE	
	BP	PENIS		HS	SCALP	
	BS	SIDE		LEG, HIP, ANKLE, BUTTOCKS	KB	BOTH KNEES
	BU	UPPER BACK			KS	KNEE
	BW	WAIST		BUTTOCK	LB	BOTH LEGS/HIPS/ ANKLES/
	BZ	TRUNK OTHER			LS	SINGLE LEG/HIP/ ANKLE/BUTTOCK
HEAD, INTERNAL	C1	SINGLE EAR INTERNAL	HAND	MB	BOTH HANDS	
	C2	BOTH EARS INTERNAL		MS	SINGLE HAND	
	C3	SINGLE EYE INTERNAL	FOOT	PB	BOTH FEET	
	C4	BOTH EYES INTERNAL		PS	SINGLE FOOT	
	CB	BRAIN	TRUNK, BONES	R1	SINGLE COLLAR BONE	
	CC	CRANIAL BONES		R2	BOTH COLLAR BONES	
	CD	TEETH		R3	SHOULDER BLADE	
	CJ	JAW		R4	BOTH SHOULDER BLADES	
	CL	THROAT, LARYNX		RB	RIB	
	CM	MOUTH		RS	STERNUM (BREAST BONE)	
	CN	NOSE		RV	VERTEBRAE (SPINE; DISC)	
	CR	THROAT, OTHER		RZ	TRUNK BONES OTHER	
	CT	TONGUE		SHOULDER	SB	BOTH SHOULDERS
CZ	HEAD OTHER INTERNAL	SS			SINGLE SHOULDER	
ELBOW	EB	BOTH ELBOWS		THUMB	TB	BOTH THUMBS
	ES	SINGLE ELBOW			TS	SINGLE THUMB
FINGER	F1	FIRST FINGER		TRUNK, INTERNAL ORGANS	V1	LUNG, SINGLE
	F2	BOTH FIRST FINGERS	V2		LUNGS, BOTH	
	F3	SECOND FINGER	V3		KIDNEY, SINGLE	
	F4	BOTH SECOND FINGERS	V4		KIDNEYS, BOTH	
	F5	THIRD FINGER	VH		HEART	
	F6	BOTH THIRD FINGERS	VL		LIVER	
	F7	FOURTH FINGER	VR		REPRODUCTIVE ORGANS	
	F8	BOTH FOURTH FINGERS	VS		STOMACH	
TOE	G1	GREAT TOE		VV	INTESTINES	
	G2	BOTH GREAT TOES		VZ	TRUNK, INTERNAL; OTHER	
	G3	TOE OTHER				
	G4	TOES OTHER				

f. NATURE OF INJURY/ILLNESS - Select the most appropriate nature of injury/illness from the list below. This nature of injury/illness shall correspond to the primary body part selected in 5e, above. Enter the nature of injury/illness name on the line and place the corresponding CODE letters in the box provided.

* The injury or condition selected below must be caused by a specific incident or event which occurred during a single work day or shift.

GENERAL NATURE CATEGORY	CODE	NATURE OF INJURY NAME			
*TRAUMATIC INJURY OR DISABILITY	TA	AMPUTATION	PARASITIC DISEASE	TU	BURN, SCALD, SUNBURN
	TB	BACK STRAIN		TI	TRAUMATIC SKIN DISEASES/ CONDITIONS INCLUDING DERMATITIS
	TC	CONTUSION; BRUISE; ABRASION		TR	TRAUMATIC RESPIRATORY DISEASE
	TD	DISLOCATION		TQ	TRAUMATIC FOOD POISONING
	TF	FRACTURE		TW	TRAUMATIC TUBERCULOSIS
	TH	HERNIA		TX	TRAUMATIC VIROLOGICAL/INFECTIVE/
GENERAL NATURE CATEGORY			CONDITION/STROKE	T1	TRAUMATIC CEREBRAL VASCULAR
	TK	CONCUSSION		T2	TRAUMATIC HEARING LOSS
	TL	LACERATION, CUT		T3	TRAUMATIC HEART CONDITION
	TP	PUNCTURE		T4	TRAUMATIC MENTAL DISORDER, STRESS; NERVOUS CONDITION
	TS	STRAIN, MULTIPLE		T8	TRAUMATIC INJURY - OTHER (EXCEPT DISEASE, ILLNESS)

** A nontraumatic physiological harm or loss of capacity produced by systemic infection; continued or repeated stress or strain; exposure to toxins, poisons, fumes, etc.; or other continued and repeated exposures to conditions of the work environment over a long period of time. For practical purposes, an occupational illness/disease or disability is any reported condition which does not meet the definition of traumatic injury or disability as described above.

GENERAL NATURE

GENERAL NATURE CATEGORY	CODE	NATURE OF INJURY NAME		
**NON-TRAUMATIC ILLNESS/DISEASE OR DISABILITY				
RESPIRATORY DISEASE	RA	ASBESTOSIS	DD	ENDEMIC DISEASE (OTHER THAN CODE TYPES R&S)
	RB	BRONCHITIS		
	RE	EMPHYSEMA	DE	EFFECT OF ENVIRONMENTAL
	RP	PNEUMOCONIOSIS	CONDITION	
	RS	SILICOSIS	DH	HEARING LOSS
	R9	RESPIRATORY DISEASE, OTHER	DK	HEART CONDITION
VIROLOGICAL, INFECTIVE & PARASITIC DISEASES			DM	MENTAL DISORDER, EMOTIONAL STRESS, NERVOUS CONDITION
	VB	BRUCELLOSIS	DR	RADIATION
	VC	COCCIDIOMYCOSIS	DS	STRAIN, MULTIPLE
	VF	FOOD POISONING	DU	ULCER
	VH	HEPATITIS	DV	OTHER VASCULAR CONDITIONS
	VM	MALARIA	D9	DISABILITY, OTHER
	VS	STAPHYLOCOCCUS		
	VT	TUBERCULOSIS	SKIN DISEASE OR	
	V9	VIROLOGICAL/INFECTIVE/ PARASITIC - OTHER	CONDITION	
			SB	BIOLOGICAL
DISABILITY, OCCUPATIONAL	DA	ARTHRITIS, BURSITIS	SC	CHEMICAL
	DB	BACK STRAIN, BACK SPRAIN	S9	DERMATITIS, UNCLASSIFIED
	DC	CEREBRAL VASCULAR CONDITION; STROKE		

g. TYPE AND SOURCE OF INJURY/ILLNESS (CAUSE) - Type and Source Codes are used to describe what caused the incident. The Type Code stands for an ACTION and the Source Code for an OBJECT or SUBSTANCE. Together, they form a brief description of how the incident occurred. Where there are two different sources, code the initiating source of the incident (see example 1, below). Examples:

(1) An employee tripped on carpet and struck his head on a desk. TYPE: 210 (fell on same level) SOURCE: 0110 (walking/working surface).

NOTE: This example would NOT be coded 120 (struck against) and 0140 (furniture).

(2) A Park Ranger contracted dermatitis from contact with poison ivy/oak.

TYPE: 510 (contact) SOURCE: 0920 (plant)

(3) A lock and dam mechanic punctured his finger with a metal sliver while grinding a turbine blade.

TYPE: 410 (punctured by) SOURCE: 0830 (metal)

(4) An employee was driving a government vehicle when it was struck by another vehicle.

TYPE: 800 (traveling in) SOURCE: 0421 (government-owned vehicle, as driver)

NOTE: The Type Code 800, "Traveling In" is different from the other type codes in that its function is not to identify factors contributing to the injury or fatality, but rather to collect data on the type of vehicle the employee was operating or traveling in at the time of the incident.

Select the most appropriate TYPE and SOURCE identifier from the list below and enter the name on the line and the corresponding code in the appropriate box.

CODE	TYPE OF INJURY NAME	CODE	SOURCE OF INJURY NAME
		0610	EXERTED
	STRUCK	0620	LIFTED, STRAINED BY (SINGLE ACTION)
0110	STRUCK BY		STRESSED BY (REPEATED ACTION)
0111	STRUCK BY FALLING OBJECT	0710	EXPOSED
0120	STRUCK AGAINST	0720	INHALED
	FELL, SLIPPED, TRIPPED	0730	INGESTED
0210	FELL ON SAME LEVEL	0740	ABSORBED
0220	FELL ON DIFFERENT LEVEL	0800	EXPOSED TO
0230	SLIPPED, TRIPPED (NO FALL)		TRAVELING IN
	CAUGHT	CODE	SOURCE OF INJURY NAME
0310	CAUGHT ON	0100	BUILDING OR WORKING AREA
0320	CAUGHT IN	0110	WALKING/WORKING SURFACE (FLOOR, STREET, SIDEWALKS, ETC.)
0330	CAUGHT BETWEEN		
	PUNCTURED, LACERATED	0120	STAIRS, STEPS
0410	PUNCTURED BY	0130	LADDER
0420	CUT BY	0140	FURNITURE, FURNISHINGS, OFFICE EQUIPMENT
0430	STUNG BY	0150	BOILER, PRESSURE VESSEL
0440	BITTEN BY	0160	EQUIPMENT LAYOUT (ERGONOMIC)
	CONTACTED	0170	WINDOWS, DOORS
0510	CONTACTED WITH (INJURED PERSON MOVING)	0180	ELECTRICITY
0520	CONTACTED BY (OBJECT WAS MOVING)		

0200	ENVIRONMENTAL CONDITION	0631	CARBON MONOXIDE
0210	TEMPERATURE EXTREME (<i>INDOOR</i>)	0640	MIST, STEAM, VAPOR, FUME
0220	WEATHER (<i>ICE, RAIN, HEAT, ETC.</i>)	0641	WELDING FUMES
0230	FIRE, FLAME, SMOKE (<i>NOT TOBACCO</i>)	0650	PARTICLES (<i>UNIDENTIFIED</i>)
0240	NOISE	0700	CHEMICAL, PLASTIC, ETC.
0250	RADIATION	0711	DRY CHEMICAL - CORROSIVE
0260	LIGHT	0712	DRY CHEMICAL - TOXIC
0270	VENTILATION	0713	DRY CHEMICAL - EXPLOSIVE
0271	TOBACCO SMOKE	0714	DRY CHEMICAL FLAMMABLE
0280	STRESS (<i>EMOTIONAL</i>)	0721	LIQUID CHEMICAL - CORROSIVE
0290	CONFINED SPACE	0722	LIQUID CHEMICAL - TOXIC
0300	MACHINE OR TOOL	0723	LIQUID CHEMICAL - EXPLOSIVE
0310	HAND TOOL (<i>POWERED; SAW, GRINDER, ETC.</i>)	0724	LIQUID CHEMICAL - FLAMMABLE
0320	HAND TOOL (<i>NONPOWERED</i>)	0730	PLASTIC
0330	MECHANICAL POWER TRANSMISSION APPARATUS	0740	WATER
0340	GUARD, SHIELD (<i>FIXED, MOVEABLE, INTERLOCK</i>)	0750	MEDICINE
0350	VIDEO DISPLAY TERMINAL	0800	INAMINATE OBJECT
0360	PUMP, COMPRESSOR, AIR PRESSURE TOOL	0810	BOX, BARREL, ETC.
0370	HEATING EQUIPMENT	0820	PAPER
0380	WELDING EQUIPMENT	0830	METAL ITEM, MINERAL
0400	VEHICLE	0831	NEEDLE
0411	AS DRIVER OF PRIVATELY OWNED/RENTAL VEHICLE	0840	GLASS
0412	AS PASSENGER OF PRIVATELY OWNED/RENTAL VEHICLE	0850	SCRAP, TRASH
0421	DRIVER OF GOVERNMENT VEHICLE	0860	WOOD
0422	PASSENGER OF GOVERNMENT VEHICLE	0870	FOOD
0430	COMMON CARRIER (<i>AIRLINE, BUS, ETC.</i>)	0880	CLOTHING, APPAREL, SHOES
0440	AIRCRAFT (<i>NOT COMMERCIAL</i>)	0900	ANIMATE OBJECT
0450	BOAT, SHIP, BARGE	0911	DOG
0500	MATERIAL HANDLING EQUIPMENT	0912	OTHER ANIMAL
0510	EARTHMOVER (<i>TRACTOR, BACKHOE, ETC.</i>)	0920	PLANT
0520	CONVEYOR (<i>FOR MATERIAL AND EQUIPMENT</i>)	0930	INSECT
0530	ELEVATOR, ESCALATOR, PERSONNEL HOIST	0940	HUMAN (<i>VIOLENCE</i>)
0540	HOIST, SLING CHAIN, JACK	0950	HUMAN (<i>COMMUNICABLE DISEASE</i>)
0550	CRANE	0960	BACTERIA, VIRUS (<i>NOT HUMAN CONTACT</i>)
0551	FORKLIFT	1000	PERSONAL PROTECTIVE EQUIPMENT
0560	HANDTRUCK, DOLLY	1010	PROTECTIVE CLOTHING, SHOES, GLASSES, GOGGLES
0600	DUST, VAPOR, ETC.		RESPIRATOR, MASK
0610	DUST (<i>SILICA, COAL, ETC.</i>)	1020	DIVING EQUIPMENT
0620	FIBERS	1021	SAFETY BELT, HARNESS
0621	ASBESTOS	1030	PARACHUTE
0630	GASES	1040	

INSTRUCTIONS FOR SECTION 6 - PUBLIC FATALITY

a. **ACTIVITY AT TIME OF ACCIDENT** - Select the activity being performed at the time of the accident from the list below. Enter the activity name on the line and the corresponding number in the box. If the activity performed is not identified on the list, select from the most appropriate primary activity area (*water related, non-water related or other activity*), the code number for "Other", and write in the activity being performed at the time of the accident.

WATER RELATED RECREATION

1. Sailing
2. Boating-powered
3. Boating-unpowered
4. Water skiing
5. Fishing from boat
6. Fishing from bank dock or pier
7. Fishing while wading
8. Swimming/supervised area
9. Swimming/designated area
10. Swimming/other area
11. Underwater activities (*skin diving, scuba, etc.*)
12. Wading
13. Attempted rescue
14. Hunting from boat
15. Other

NON-WATER RELATED RECREATION

16. Hiking and walking
17. Climbing (*general*)
18. Camping/picnicking authorized area

19. Camping/picnicking unauthorized area
20. Guided tours
21. Hunting
22. Playground equipment
23. Sports/summer (*baseball, football, etc.*)
24. Sports/winter (*skiing, sledding, snowmobiling etc.*)
25. Cycling (*bicycle, motorcycle, scooter*)
26. Gliding
27. Parachuting
28. Other non-water related

OTHER ACTIVITIES

29. Unlawful acts (*fight, riots, vandalism, etc.*)
30. Food preparation/serving
31. Food consumption
32. Housekeeping
33. Sleeping
34. Pedestrian struck by vehicle
35. Pedestrian other acts
36. Suicide
37. "Other" activities

b. **PERSONAL FLOTATION DEVICE USED** - If fatality was water-related was the victim wearing a person flotation device? Mark the appropriate box.

INSTRUCTIONS FOR SECTION 7 - MOTOR VEHICLE ACCIDENT

a. **TYPE OF VEHICLE** - Mark appropriate box for each vehicle involved. If more than one vehicle of the same type is involved, mark both halves of the appropriate box. USACE vehicle(s) involved shall be marked in left half of appropriate box.

b. **TYPE OF COLLISION** - Mark appropriate box.

c. **SEAT BELT** - Mark appropriate box.

INSTRUCTIONS FOR SECTION 8 - PROPERTY/MATERIAL INVOLVED

a. **NAME OF ITEM** - Describe all property involved in accident. Property/material involved means material which is damaged or whose use or misuse contributed to the accident. Include the name, type, model; also include the National Stock Number (NSN) whenever applicable.

b. **OWNERSHIP** - Enter ownership for each item listed. (Enter one of the following: USACE; OTHER GOVERNMENT; CONTRACTOR; PRIVATE)

c. **\$ AMOUNT OF DAMAGE** - Enter the total estimated dollar amount of damage (parts and labor), if any.

INSTRUCTIONS FOR SECTION 9 - VESSEL/FLOATING PLANT ACCIDENT

a. **TYPE OF VESSEL/FLOATING PLANT** - Select the most appropriate vessel/floating plant from list below. Enter name and place corresponding number in box. If item is not listed below, enter item number for "OTHER" and write in specific type of vessel floating plant.

VESSEL/FLOATING PLANTS

1. ROW BOAT
2. SAIL BOAT
3. MOTOR BOAT
4. BARGE
5. DREDGE/HOPPER
6. DREDGE/SIDE CASTING
7. DREDGE/DIPPER
8. DREDGE/CLAMSHELL, BUCKET
9. DREDGE/PIPE LINE
10. DREDGE/DUST PAN
11. TUG BOAT
12. OTHER

b. **COLLISION/MISHAP** - Select from the list below the object(s) that contributed to the accident or were damaged in the accident.

COLLISION/MISHAP

1. COLLISION W/OTHER VESSEL
2. UPPER GUIDE WALL
3. UPPER LOCK GATES
4. LOCK WALL
5. LOWER LOCK GATES
6. LOWER GUIDE WALL
7. HAULAGE UNIT
8. BREAKING TOW
9. TOW BREAKING UP
10. SWEEPED DOWN ON DAM
11. BUOY/DOLPHIN/CELL
12. WHARF OR DOCK
13. OTHER

INSTRUCTIONS FOR SECTION 10 - ACCIDENT DESCRIPTION

DESCRIBE ACCIDENT - Fully describe the accident. Give the sequence of events that describe what happened leading up to and including the accident. Fully identify personnel and equipment involved and their role(s) in the accident. Ensure that relationships between personnel and equipment are clearly specified. Continue on blank sheets if necessary and attach to this report.

INSTRUCTIONS FOR SECTION 11 - CAUSAL FACTORS

a. Review thoroughly. Answer each question by marking the appropriate block. If any answer is yes, explain in item 13 below. Consider, as a minimum, the following:

- (1) **DESIGN** - Did inadequacies associated with the building or work site play a role? Would an improved design or layout of the equipment or facilities reduce the likelihood of similar accidents? Were the tools or other equipment designed and intended for the task at hand?
- (2) **INSPECTION/MAINTENANCE** - Did inadequately or improperly maintained equipment, tools, workplace, etc. create or worsen any hazards that contributed to the accident? Would better equipment, facility, work site or work activity inspections have helped avoid the accident?
- (3) **PERSON'S PHYSICAL CONDITION** - Do you feel that the accident would probably not have occurred if the employee was in "good" physical condition? If the person involved in the accident had been in better physical condition, would the accident have been less severe or avoided altogether? Was over exertion a factor?
- (4) **OPERATING PROCEDURES** - Did a lack of or inadequacy within established operating procedures contribute to the accident? Did any aspect of the procedures introduce any hazard to, or increase the risk associated with the work process? Would establishment or improvement of operating procedures reduce the likelihood of similar accidents?
- (5) **JOB PRACTICES** - Were any of the provisions of the Safety and Health Requirements Manual (EM 385-1-1) violated? Was the task being accomplished in a manner which was not in compliance with an established job hazard analysis or activity hazard analysis? Did any established job practice (including EM 385-1-1) fail to adequately address the task or work process? Would better job practices improve the safety of the task?
- (6) **HUMAN FACTORS** - Was the person under undue stress (either internal or external to the job)? Did the task tend toward overloading the capabilities of the person; i.e., did the job require tracking and reacting to many external inputs such as displays, alarms, or signals? Did the arrangement of the workplace tend to interfere with efficient task performance? Did the task require reach, strength, endurance, agility, etc., at or beyond the capabilities of the employee? Was the work environment ill-adapted to the person? Did the person need more training, experience, or practice in doing the task? Was the person inadequately rested to perform safely?
- (7) **ENVIRONMENTAL FACTORS** - Did any factors such as moisture, humidity, rain, snow, sleet, hail, ice, fog, cold, heat, sun, temperature changes, wind, tides, floods, currents, dust, mud, glare, pressure changes, lightning, etc., play a part in the accident?

- (8) CHEMICAL AND PHYSICAL AGENT FACTORS - Did exposure to chemical agents (*either single shift exposure or long-term exposure*) such as dusts, fibers (*asbestos, etc.*), silica, gases (*carbon monoxide, chlorine, etc.*), mists, steam, vapors, fumes, smoke, other particulates, liquid or dry chemicals that are corrosive, toxic, explosive or flammable, by products of combustion or physical agents such as noise, ionizing radiation, non-ionizing radiation (*UV radiation created during welding, etc.*) contribute to the accident/incident?
- (9) OFFICE FACTORS - Did the fact that the accident occurred in an office setting or to an office worker have a bearing on its cause? For example, office workers tend to have less experience and training in performing tasks such as lifting office furniture. Did physical hazards within the office environment contribute to the hazard?
- (10) SUPPORT FACTORS - Was the person using an improper tool for the job? Was inadequate time available or utilized to safely accomplish the task? Were less than adequate personnel resources (*in terms of employee skills, number of workers, and adequate supervision*) available to get the job done properly? Was funding available, utilized, and adequate to provide proper tools, equipment, personnel, site preparation, etc.?
- (11) PERSONAL PROTECTIVE EQUIPMENT - Did the person fail to use appropriate personal protective equipment (*gloves, eye protection, hard-toed shoes, respirator, etc.*) for the task or environment? Did protective equipment provided or worn fail to provide adequate protection from the hazard(s)? Did lack of or inadequate maintenance of protective gear contribute to the accident?
- (12) DRUGS/ALCOHOL - Is there any reason to believe the person's mental or physical capabilities, judgment, etc., were impaired or altered by the use of drugs or alcohol? Consider the effects of prescription medicine and over the counter medications as well as illicit drug use. Consider the effect of drug or alcohol induced "hangovers".
- b. WRITTEN JOB/ACTIVITY HAZARD ANALYSIS - Was a written Job/Activity Hazard Analysis completed for the task being performed at the time of the accident? Mark the appropriate box. If one was performed, attach a copy of the analysis to the report.

INSTRUCTIONS FOR SECTION 12 - TRAINING

- a. WAS PERSON TRAINED TO PERFORM ACTIVITY/TASK? - For the purpose of this section "trained" means the person has been provided the necessary information (*either formal and/or on-the-job (OJT) training*) to competently perform the activity/task in a safe and healthful manner.
- b. TYPE OF TRAINING - Mark the appropriate box that best indicates the type of training; (*classroom or on-the-job*) that the injured person received, before the accident happened.
- c. DATE OF MOST RECENT TRAINING - Enter YYYYMMDD of the last formal training completed that covered the activity task being performed at the time of the accident.

INSTRUCTIONS FOR SECTION 13 - CAUSES

- a. DIRECT CAUSES - The direct cause is that single factor, which most directly lead to the accident. See examples below.
- b. INDIRECT CAUSES - Indirect causes are those factors which contributed to but did not directly initiate the occurrence of the accident.

Examples for section 13:

- a. Employee was dismantling scaffold and fell 12 feet from unguarded opening.

Direct cause: failure to provide fall protection at elevation. Indirect causes: failure to enforce USACE safety requirements; improper training/motivation of employee (*possibility that employee was not knowledgeable of USACE fall protection requirements or was lax in his attitude towards safety*); failure to ensure provision of positive fall protection whenever elevated; failure to address fall protection during scaffold dismantling in phase hazard analysis.

- b. Private citizen had stopped his vehicle at intersection for red light when vehicle was struck in rear by USACE vehicle. (*Note: USACE vehicle was in proper/safe working condition*).

Direct cause: failure of USACE driver to maintain control of and stop USACE vehicle within safe distance.

Indirect cause: failure of employee to pay attention to driving (*defensive driving*).

INSTRUCTIONS FOR SECTION 14 - ACTION TO ELIMINATE CAUSE(s)

DESCRIPTION - Fully describe all the actions taken, anticipated, and recommended to eliminate the cause(s) and prevent reoccurrence of similar accidents/illnesses. Continue on blank sheets of paper if necessary to fully explain and attach to the completed report form.

INSTRUCTIONS FOR SECTION 15 - DATES FOR ACTION

- a. **BEGIN DATE** - Enter the date YYYYMMDD when the corrective action(s) identified in section 14 will begin.
- b. **COMPLETE DATE** - Enter the date YYYYMMDD when the corrective action(s) identified in section 14 will be completed.
- c. **DATE SIGNED** - Enter YYYYMMDD that the report was signed by the responsible supervisor.
- d.e.. **TITLE AND SIGNATURE** - Enter the title and signature of supervisor completing the accident report. For a GOVERNMENT employee accident/illness the immediate supervisor will complete and sign the report. For PUBLIC accidents the USACE Project Manager/Area Engineer responsible for the USACE property where the accident happened shall complete and sign the report. For CONTRACTOR accidents the Contractor's project manager shall complete and sign the report and provide to the USACE supervisor responsible for oversight of that contractor activity. This USACE supervisor shall also sign the report. Upon entering the information required in 15c., 15d., 15e., 15f. and 15g. below, the responsible USACE supervisor shall forward the report for management review as indicated in section 16.

f. **ORGANIZATION NAME** - For GOVERNMENT employee accidents enter the USACE organization name (*Division, Branch, Section, etc.*) of the injured employee. For PUBLIC accidents enter the USACE organization name for the person identified in block 15d. For CONTRACTOR accidents enter the USACE organization name for the USACE office responsible for providing contract administration oversight.

g. **OFFICE SYMBOL** - Enter the latest complete USACE Office Symbol for the USACE organization identified in block 15f.

INSTRUCTIONS FOR SECTION 16 - MANAGEMENT REVIEW (1st)

1ST REVIEW - Each USACE FOA shall determine who will provide 1st management review. The responsible USACE supervisor in section 15d. shall forward the completed report to the USACE office designated as the 1st Reviewer by the FOA. Upon receipt, the Chief of the Office shall review the completed report, mark the appropriate box, provide substantive comments, sign, date, and forward to the FOA Staff Chief (*2nd review*) for review and comment.

INSTRUCTIONS FOR SECTION 17 - MANAGEMENT REVIEW (2nd)

2ND REVIEW - The FOA Staff Chief (*i .e., FOA Chief of Construction, Operations, Engineering, Planning, etc.*) shall mark the appropriate box, review the completed report, provide substantive comments, sign, date, and return to the FOA Safety and Occupational Health Office.

INSTRUCTIONS FOR SECTION 18 - SAFETY AND OCCUPATIONAL HEALTH REVIEW

3RD REVIEW - The FOA Safety and Occupational Health Office shall review the completed report, mark the appropriate box, ensure that any inadequacies, discrepancies, etc. are rectified by the responsible supervisor and management reviewers, provide substantive comments, sign, date and forward to the FOA Commander for review, comment, and signature.

INSTRUCTION FOR SECTION 19 - COMMAND APPROVAL

4TH REVIEW - The FOA Commander shall (*to include the person designated Acting Commander in his absence*) review the completed report, comment if required, sign, date, and forward the report to the FOA Safety and Occupational Health Office. Signature authority shall not be delegated.