

U.S. Department of Energy  
**INDIVIDUAL ACCIDENT/INCIDENT REPORT**  
Official Use Only - Privacy Act

**General Information**

1. Organization Name: \_\_\_\_\_  
Organization Code: \_\_\_\_\_
2. Case Number: \_\_\_\_\_ Revision:  Yes
3. Did accident involve more than one reporting organization?  
 Yes  No
- Multiple Case Number: \_\_\_\_\_
4. Accident Type:  Injury/Illness  Vehicle  
 Property Damage  Other
5. Investigation Type:  A  B  C  Non-recordable
6. Department, Division, or I.D. Code: \_\_\_\_\_
7. Date of Occurrence: \_\_\_\_\_  
Month Day Year (YYYY)
8. Time of Event: \_\_\_\_\_ (Military)
9. Accident Occurred:  Indoors  Outdoors
10. On Employer's Premise:  Yes  No
11. Specific Location: \_\_\_\_\_

**Employee Information**

12. Check One:  Injury/Illness Employee  
 Operator of Equipment/Vehicle  
 Not Applicable
13. Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_
14. Social Security No. \_\_\_\_\_
15. Date of Birth: \_\_\_\_\_  
Month Day Year (YYYY)
16. Sex:  Female  Male
17. Occupation: \_\_\_\_\_
18. Time Employee Began Work: \_\_\_\_\_ (Military)
19. Date of Hire: \_\_\_\_\_  
Month Day Year (YYYY)
20. Experience on this Job/Equipment:  Under 3 Months  
 3 to 12 Months  
 Over 12 Months

(If Property Damage or Vehicle Accident, Go to Line 26)

**Injury/Illness (OSHA Information)**

21.  Injury Code (10)  
Illness Codes  
 Code 7a(21) - Skin disease or disorders  
 Code 7b(22) - Dust diseases of lungs  
 Code 7c(23) - Resp. due to toxic agents  
 Code 7d(24) - Poisoning  
 Code 7e(25) - Disorders-Physical agents  
 Code 7f(26) - Disorders-Repeated trauma  
 Code 7g(29) - All others
22. Workdays Lost: \_\_\_\_\_  
(Actual if available or estimated expected)
23. Workdays Restricted: \_\_\_\_\_  
(Actual if available or estimated expected)
24. Has employee returned to work with no further anticipated workdays lost or restricted?  
 Yes  No
25. Permanent transfer to different job because of accident?  
 Yes  No  
Terminated because of accident?  
 Yes  No
26. Did employee die?  Yes  No
- If "Yes," enter date \_\_\_\_\_  
Month Day Year (YYYY)



**Property/Vehicle Damage**

27. Property Loss Type (Select One)

- Fire/Smoke:  Building  Brush  Vehicle  Other
- Electrical:  Equipment Contact  Wiring  Overload  Insulation  Polarity  Grounding  Other
- Explosion:  Vapor  Chemical  Fluids  High Explosives  Dust
- Mechanical:  Linear energy  Rotational Energy  Pressure  Falls  Mechanical Breakdown  Overload
- Acts of Nature:  Wind  Rain/Hail  Flood  Freezing/Snowlightning  Earthquake  Other
- Leaks, Spills,  
Releases, or  
Contamination:  Chemical  Nuclear  Environmental Impairment  Other
- Miscellaneous:  Thermal  Corrosion  Water Damage  Sabotage  Other

(If Property Damage Accident go to Line 30)

28. Vehicle Type (Select One)

- Light Highway:  Automobile  Van  
 Pickup truck  Motorcycle, moped  Highway vehicle, n.e.c.
- Heavy Highway:  Bus  Delivery truck  Dump truck  Semitrailer, tractor trailer, trailer truck  Truck, n.e.c. (e.g., fire truck)
- Air Rotary Wing:  Helicopter  Aircraft--rotary wing, n.e.c.
- Air Fixed Wing:  Jet  Propeller--driven aircraft  Aircraft fixed wing, n.e.c.
- Other Vehicles:  Railroad  Marine

29. Was vehicle equipped with seat belts?  Yes  No  
If "Yes," was seat belt in use?  Yes  No

30. Did vehicle accident involve recordable injury?  Yes  No

31. Total Accident Damage \$

DOE Property/Vehicle \$

Non- DOE Property/Vehicle \$

32. Claim Against DOE \$  Paid by DOE \$

Reimbursable to DOE \$  Paid to DOE \$

33. Are the dollar amounts final?  Yes  No

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**Equipment/Hardware/Vehicle Involved (as applicable)**

34. #1 Equipment \_\_\_\_\_  
Generic (or brand) name and model

#2 Equipment \_\_\_\_\_  
Generic (or brand) name and model

35. Did equipment design or defect contribute to accident cause or severity?  Yes  No

### NARRATIVE GUIDE

**DO NOT INCLUDE THE NAME (OR OTHER PERSONAL IDENTIFIER) OF THE EMPLOYEE/OPERATOR OR WITNESS IN THIS SECTION.**

Use third person references, e.g., he slipped on the wet floor and broke his right toe.

36. Activity in progress at time of accident. Be specific. For example, if the employee was using, equipment or handling materials or chemicals, name them and tell what he was doing with them.

37. Events Describe the accident sequentially, beginning with initiating events. Tell what happened, how it happened and end with nature and extent of injury/damage. Use a separate sheet for additional space.

Name any objects or substances (e.g., utility knife, glass beaker containing saline solution) involved and tell how they were involved.

Describe the nature of the injury/illness/damage. Name the body part effected if injury or illness. (e.g., amputation of right index finger at second joint)

Name and address of primary health care provider (e.g., physician, nurse, etc.) \_\_\_\_\_

If hospitalized overnight, name and address of hospital \_\_\_\_\_

38. Accident Causes

a. Conditions

b. Actions

c. Factors influencing a or b.

39. Corrective Actions (if risk is acceptable, corrective action may not be necessary. If so, indicate "Not applicable" in section "a." below.)

a. Actions taken

b. Actions recommended

c. To be completed by \_\_\_\_\_  
Implementation Date

40. Report Prepared by \_\_\_\_\_ Date \_\_\_\_\_ Telephone \_\_\_\_\_

Official Position  Supervisor  Safety Professional  Other

41. Supervisor responsible for Corrective Action \_\_\_\_\_ Date \_\_\_\_\_ Telephone \_\_\_\_\_

42. Accident Investigation Contact  
(if different from line 40) \_\_\_\_\_ Telephone \_\_\_\_\_