

# ENGEL ELECTRIC CO.

## ACCIDENT REPORT

ENGEL ELECTRIC's Office Staff will complete the State of Illinois Form 45 and submit it to our insurance carrier and the State of Illinois.

**All employers must report *orally* to OSHA within 8 hours of learning of any occupational related fatality or incident requiring hospitalization of three or more employees. The 8 hour limit begins as soon as "any agent or employee" of the employer is notified. A work-related incident is defined as "on the employer's premises", or while the employee is working "off-premises".**

**Accident reports must be completed within 24 hours of the accident.**

***REMINDER:***

Illinois Statutes state: ***Any delay in the notice to the employer may reduce or delay the payment of benefits.***

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1514 West Fourth Street Sterling, IL 61081  
Sterling, IL 61081

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**EMPLOYEE INFORMATION**

NAME \_\_\_\_\_ (last) \_\_\_\_\_ (first) \_\_\_\_\_ (m.i.)

SOCIAL SECURITY NUMBER \_\_\_\_\_

HOME PHONE NUMBER \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ (street)

\_\_\_\_\_ (city) \_\_\_\_\_ (state, zip)

JOB TITLE \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_

LENGTH OF EMPLOYMENT AT THIS COMPANY \_\_\_\_\_

**JOB SITE INFORMATION**

ADDRESS OF ACCIDENT \_\_\_\_\_ (street)

\_\_\_\_\_ (city) \_\_\_\_\_ (state, zip)

WORKING CONDITIONS:  INSIDE  OUTSIDE TEMPERATURE: \_\_\_\_\_

RAIN - SNOW - BLOWING SNOW - DRIZZLE - CLEAR - OVERCAST - SUNSHINE - WINDY - ICY  
*(circle all conditions that apply)*

OTHER CONDITIONS AFFECTING ACCIDENT \_\_\_\_\_

\_\_\_\_\_

**ACCIDENT DATA**

INJURY DATE \_\_\_\_\_ TIME \_\_\_\_\_ (AM) (PM)

FOREMAN \_\_\_\_\_

DATE EMPLOYEE LAST WORKED \_\_\_\_\_

DATE EMPLOYER NOTIFIED \_\_\_\_\_

DATE (or estimated date) OF RETURN TO WORK \_\_\_\_\_

TOTAL LOST TIME \_\_\_\_\_

DRAW A DIAGRAM ON THE BACK OF THIS PAGE THAT BEST ILLUSTRATES HOW THIS ACCIDENT HAPPENED.

WHAT TYPE OF INJURIES WERE INCURRED? - (Circle what applies).

- |     |                  |                |            |                         |
|-----|------------------|----------------|------------|-------------------------|
| 1.  | Cut              | Puncture       | Laceration |                         |
| 2.  | Sprain           | Strain         | Hernia     |                         |
| 3.  | Scratch          | Bruise         | Abrasion   | Contusion               |
| 4.  | Burn             | (Heat)         | (Chemical) | Degree: 1st - 2nd - 3rd |
| 5.  | Insect Bite      | Plant Reaction |            |                         |
| 6.  | Fracture         | Crush          | Pinch      |                         |
| 7.  | Foreign Particle |                |            |                         |
| 8.  | Disease          |                |            |                         |
| 9.  | Amputation       |                |            |                         |
| 10. | Death            |                |            |                         |
| 11. | Other _____      |                |            |                         |

PART OF BODY EFFECTED - (Circle what applies.)

- |     |              |     |     |     |     |     |
|-----|--------------|-----|-----|-----|-----|-----|
| 1.  | Eye          | (L) | (R) | (B) |     |     |
| 2.  | Hand         | (L) | (R) | (B) |     |     |
| 3.  | Finger       | (T) | (I) | (M) | (R) | (S) |
| 4.  | Back (upper) | (L) | (R) |     |     |     |
| 5.  | Back (lower) | (L) | (R) |     |     |     |
| 6.  | Knee         | (L) | (R) | (B) |     |     |
| 7.  | Wrist        | (L) | (R) | (B) |     |     |
| 8.  | Arm          | (L) | (R) | (B) |     |     |
| 9.  | Elbow        | (L) | (R) | (B) |     |     |
| 10. | Leg          | (L) | (R) | (B) |     |     |
| 11. | Foot         | (L) | (R) | (B) |     |     |
| 12. | Ankle        | (L) | (R) | (B) |     |     |
| 16. | Head         |     |     |     |     |     |
| 17. | Neck         |     |     |     |     |     |
| 18. | Face         |     |     |     |     |     |
| 19. | Other _____  |     |     |     |     |     |

WHAT SOURCE WAS INVOLVED IN THE INJURY? (Circle what applies.)

1. Hand Tools (specify) \_\_\_\_\_
2. Machines or Equipment (specify) \_\_\_\_\_
3. Ladders - Scaffolds \_\_\_\_\_
4. Loading (moving equipment, lifting parts, etc.) \_\_\_\_\_
5. Vehicle(s) (specify) \_\_\_\_\_
6. Working Surfaces \_\_\_\_\_
7. Environmental Conditions \_\_\_\_\_
8. Other \_\_\_\_\_

TYPE OF ACCIDENT - (Circle what applies, describe where necessary)

- 1. Fall from \_\_\_\_\_
- 2. Slipped on \_\_\_\_\_
- 3. Struck by \_\_\_\_\_
- 4. Small airborne particles \_\_\_\_\_
- 5. Lifting - Twisting - Bending - Pushing - Pulling \_\_\_\_\_
- 6. Chemical Spray or Splash \_\_\_\_\_
- 7. Other \_\_\_\_\_

Describe in detail the employees activities at the time of the accident. \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL TREATMENT**

Was the employee (sent) (taken) to Doctor, Clinic or Hospital for treatment  yes  no

What was the treatment date? \_\_\_\_\_

Name, Address & Phone # of Hospital or Clinic \_\_\_\_\_  
\_\_\_\_\_

Name, Address & Phone # of Attending Physician \_\_\_\_\_  
\_\_\_\_\_

Are there any restrictions?  yes  no

Describe restrictions \_\_\_\_\_  
\_\_\_\_\_

**SAFETY RULES**

**PLEASE ANSWER THE FOLLOWING SAFETY QUESTIONS TO THE BEST OF YOUR ABILITY.**

Is the employee taking any prescribed medications?  yes  no

What safety devices were in use? (specify: hard-hats, glasses, shoes, tools, scaffolds, tie-offs, belts, etc.) \_\_\_\_\_  
\_\_\_\_\_

Was there a failure of safety devices?  yes  no

Was there a failure to use safety devices?  yes  no

SAFETY RULES. continued

Describe any failures of, or failures to use safety devices \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What safety rules were in effect? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were all safety rules obeyed?  yes  no

If "no", what safety rules were not obeyed? \_\_\_\_\_  
\_\_\_\_\_

What safety rules SHOULD HAVE BEEN IN EFFECT to prevent this accident? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ANALYSIS**

What was the primary cause of the accident? \_\_\_\_\_  
\_\_\_\_\_

What was the secondary cause of the accident? \_\_\_\_\_  
\_\_\_\_\_

What else contributed to the accident? \_\_\_\_\_  
\_\_\_\_\_

**CORRECTIVE ACTIONS**

What steps can be taken to prevent recurrence of this or similar accidents? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Can any preventative or corrective action be taken immediately?  yes  no

If "yes", please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What has been done thus far to prevent recurrence? \_\_\_\_\_  
\_\_\_\_\_

**EYEWITNESSES**

Names of Eyewitnesses:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

**NOTE:** Each eyewitness shall complete an independent report, sign it and attach it to this form. No exceptions.

*The "Eyewitness Statement" report form follows this page. Copy the blank form as many times as necessary to provide a form for each eyewitness.*

**In cases of serious injury or death, ALL eyewitnesses must fill out an independent "Eyewitness Statement" report form.**

\_\_\_\_\_

To the best of my knowledge, I hereby certify that the information contained in this report is accurate.

\_\_\_\_\_  
*Supervisor's Signature*

\_\_\_\_\_  
*Supervisor's Name (please print)*

\_\_\_\_\_  
*Date*

**EYEWITNESS STATEMENT**

1. NAME OF INJURED EMPLOYEE \_\_\_\_\_

2. NAME OF WITNESS (your name) \_\_\_\_\_

3. DESCRIBE WHAT THE EMPLOYEE WAS DOING AT THE TIME OF THE ACCIDENT.

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

4. BASED ON THE FACTS AND YOUR OBSERVATIONS, HOW DID THE ACCIDENT HAPPEN?

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

5. WHERE DID THE ACCIDENT HAPPEN? (*location-include address*) \_\_\_\_\_

\_\_\_\_\_

6. WERE ALL SAFETY RULES BEING FOLLOWED?  yes  no

7. WERE ALL REQUIRED SAFETY DEVICES AND PROTECTION EQUIPMENT PROPERLY WORN?  yes  no

8. WERE ALL REQUIRED SAFETY DEVICES AND PROTECTION EQUIPMENT PROPERLY USED?  yes  no

9. IF THE ANSWER(S) TO QUESTIONS 6, 7 OR 8 WERE "NO", PLEASE EXPLAIN.

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

10. PLEASE DRAW A DIAGRAM OF THE ACCIDENT ON THE BACK OF THIS PAGE.

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

To the best of my knowledge, I hereby certify that the information contained in this report is accurate.

\_\_\_\_\_  
*Eyewitness Signature*                      *Eyewitness Name (please print)*                      *Date*