

ATTACHMENT C

FORMS

Project Health and Safety Plan Acceptance Form

Safety Meeting Attendance Log

Parsons Incident/Accident Report Form and Instructions

Army Accident Report Form and Instructions (ENG FORM 3394)

Accident Report Follow-Up Form

Parsons Project Incident/Accident Report Form

PLEASE PRINT

Attach all supplemental documentation, including photos, diagrams, witness statements and field reports

PROJECT Information	Project Title	Location
	Subcontractor	
	Address	
	City, State, Zip	
	Contact Name	Phone Number

INCIDENT Type	<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> General Liability	<input type="checkbox"/> Builder's Risk
	<input type="checkbox"/> Emergency Response Notified (Police, Fire, Medic, etc.)	<input type="checkbox"/> Bodily Injury/Illness	<input type="checkbox"/> Equipment
	<input type="checkbox"/> First-Aid Only	<input type="checkbox"/> Real Property Damage	<input type="checkbox"/> Supplies
	<input type="checkbox"/> Recordable Injury	<input type="checkbox"/> Personal Property Damage	<input type="checkbox"/> Machinery
		<input type="checkbox"/> Utility Property Damage	<input type="checkbox"/> Work

Incident Location	Date of Loss	Time of Loss
	Place (exact location)	

Incident Description	Detailed Description of Accident
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Worker's Comp Or Personal Injury (circle one)	Injured Name		
	Address		
	City, State, Zip		
	Home Phone	Date of Birth	
	Nature of Injury		
	Medical Facility	Work Status	
	Treatment Received		

Property Damage Or Builder's Risk (circle one)	Owner's Name		
	Address		
	City, State, Zip		
	Home Phone	Work Phone	
	Damage Type	Estimated Cost	
	Utility Type	Marked or Unmarked	
	Description of Damage		

WITNESS Information	Name		
	Address		
	City, State, Zip		
	Home Phone	Work Phone	
	Where to contact	Time to contact	

Contractor Subcontractor Action	Describe actions taken

Signature _____
 Print Name _____
 Phone No. _____

Employer _____
 Date _____
 Fax Number _____

On-Line Safety Reporting System

Policy Requirements

- Initial incident reports for all incidents, including near misses, shall be reported within 4 hours.
- Detail incident reports are required within 24 hours.
- Reporting is done via on-line (PWeb) incident report form.
- Injuries with Days Away from Work - immediate supervisor and PM must teleconference with GBU President within 4 hours.
- Projects enter hours via on-line form by FIRST Friday of new period.

Reporting Incidents

Corporate policy requires that all employees report safety incidents to their supervisor immediately. Supervisors must report all incidents to the appropriate Project Manager (Department Manager if the incident is not related to a project), who must officially report the incident to the GBU within four hours. This official reporting is done via the PWeb, unless PWeb is unavailable, in which case the incident can be reported by email, fax or telephone.

“Incidents” include work related injuries, work related illness, accidents with property damage only and near misses. “Near misses” are any unplanned event that had the potential to (but did not) result in injury or property damage.

Incident reports should reflect the best available information at the time. Where exact information is not known (recordability, days away from work, etc.) the PM’s best judgment should be used when completing the initial incident report. This information can be subsequently revised when the detail incident report is submitted.

When in doubt, submit an initial report or contact the GBU Safety Manager.

On-line Reporting System

The on-line reporting system can be found on the PI&T Safety Page on PWeb. To locate the system, follow these steps:

1. From the Corporate PWeb Homepage, select PI&T from the Org Units menu
2. Locate and select “Safety” from the list of pages in the right hand column
3. Select the “Incident Reporting Form” link

To create and submit a new incident report, select the orange “Add” button from the main page of the reporting system. To update an existing incident report or complete the Detail Incident page, locate and select the appropriate incident from the list.

Creating or Updating Incidents

The Initial Incident page of the report must be completed within four hours of the incident occurring. This page includes basic information needed for the first notification to our insurance carriers. If possible, all of the fields should be completed in the initial report. A list is provided at the end of this document describing all fields contained on the initial incident page.

Incident Detail Reports

Within 24 hours of the incident occurring, the Incident Detail page of the on-line report must be completed. This page includes detailed information about the injured party, the nature and extent of injuries, medical treatment provided, corrective actions taken, and witness statements. In the event of property damage, this page also includes descriptive information on the property owner. Finally, the page includes a section to include electronic attachments. These might include photographs, signed witness statements, etc.

Monthly Reporting of Hours

Hours must be entered into the on-line reporting system no later than the first Friday of the new period. If an accurate accounting of hours is not available, estimated hours are submitted into the system. The estimated hours can be revised later in the month, or the following month, when accurate data is available.

From the "Hours" page, select the GBU and the period (month and year) that is being reported. The system only allows hours to be entered for the period selected. MTD and PTD figures are calculated totals based on the sum of all monthly entries. To enter or correct a prior period entry, simply select that month from the drop-down box and correct the figures for that month.

Be sure to select the correct month and year when entering hours.

Hours must be entered for each (as applicable) of six different labor categories. The categories are as follows:

- Contractor (Field/Craft)
- Contractor (Office/Admin)
- JV Partner (Field/Craft)
- JV Partner (Office/Admin)
- Parsons Employee (Field/Craft)
- Parsons Employee (Office/Admin)

Monthly Statistics Summary Reports

The on-line reporting system automatically calculates incident rates based on incidents and hours entered into the system. To view the statistics, select the "Reports" page from the on-line system. Select "Parsons Safety Statistics Summary", the appropriate GBU, and the appropriate period. (NOTE: The system does not yet provide reports at the Division and Sector level. That enhancement is pending.) Use the checkboxes to select the labor categories desired.

Contact Rick McAlpin or Jim Owen for Assistance

Initial Incident Report Fields

1. **GBU** – Select the GBU from the drop down box. Incidents are reported primarily by project, and the GBU should reflect the unit responsible for the project. This may be different from the GBU that employs the person injured.
2. **Field Project Name, Office Location or Other** – If the applicable project is listed in the “Field Project” list, select from that box. If not, and if the incident occurred in a Parsons corporate office, select the office from the drop box. Otherwise, type in the name of the responsible organizational unit in the “Other” field. The GBU must be selected BEFORE attempting to select a Project/Office. Do NOT select both a field project AND an Office Location (or Other). If the appropriate Project or Office name can not be found, manually enter it into the “Other” field.
3. **Job and WBS Numbers** – These fields should reflect the charge number responsible for the incident. In general, that will be the number that the employee was charging at the time of the incident. Projects are responsible for visitors, regardless of what charge number they use while visiting the job. For example, if the Division Manager is injured while visiting Project X, the project number is entered, not the division overhead account.
4. **Near Miss** – Check this box if the report is for a near miss only (no injury or property damage occurred).
5. **Emergency Response Notified** – Check this box if fire, police or ambulance was called as a result of the incident.
6. **Three or More Employees Hospitalized** – Check this box if three or more employees were injured as the result of a single incident. In this case, the GBU or Corporate Safety Manager must also be immediately notified by telephone.
7. **Extent of Injury** – Select the appropriate radio button. First aid cases are as defined by OSHA 1904 criteria. All other injuries are considered recordable.
8. **Restricted Duty (# of days)** – If the injured person was limited (by a physician) to less than normal work duration or duties, enter the number of days. Estimate the days if unknown, and correct the number later. NOTE: this is the number of CALENDAR days (not scheduled work days), and it does NOT include the day of the injury.
9. **Days Away From Work (# of days)** – If the injured person was ordered by a physician not to return to work, enter the number of days missed. Estimate the days if unknown, and correct the number later. NOTE: this is the number of CALENDAR days (not scheduled work days), and it does NOT include the day of the injury. Injuries with Days Away From Work require a phone call to the GBU President within 4 hours.
10. **Fatality (Date of Death)** – In the event of a work related fatality, enter the date of death here. NOTE: Fatalities require immediate phone notification of the Division Manager, GBU President, GBU Safety Manager, and Corporate Safety Manager.
11. **Property Damage** – Check the appropriate boxes if applicable.
12. **Place** – Describe the exact location that incident occurred. For example, “in the north stairwell of building 21, between the second and third floor.”
13. **Date** – This field reflects the date the incident occurred, not necessarily the date it was reported. If the exact date is not known, an estimate should be used.
14. **Time** – This field reflects the time of day that the incident occurred. If the exact time is not known, an estimate should be used.
15. **Incident Description** – Provide a detailed description of the incident. This is a memo field and text will scroll down the window as it is entered. Use as much space as needed to accurately describe the incident and the resulting injuries.

16. Reported by – This field defaults to the employee login ID that was used to access PWeb. However, the field can be over-written if needed.
17. Name – First and last name of the injured party.
18. Status – Select the most appropriate category from the drop box (Employee - Field, Subcontractor - Field, Partner - Field, Employee - Office, Subcontractor - Office, Partner - Office or 3rd Party).
19. Trade/Function – Select the most appropriate category from the drop box.

(For Safety Staff only)	REPORT NO.	EROC CODE	UNITED STATES ARMY CORPS OF ENGINEERS ACCIDENT INVESTIGATION REPORT <i>(For Use of this Form See Help Menu and USACE Suppl to AR 385-40)</i>			REQUIREMENT CONTROL SYMBOL: CEEC-S-8(R2)
1. ACCIDENT CLASSIFICATION						
PERSONNEL CLASSIFICATION		INJURY/ILLNESS/FATAL		PROPERTY DAMAGE		MOTOR VEHICLE INVOLVED
REGIMENT <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"/> CONTRACTOR		<input type="checkbox"/>		<input type="checkbox"/> FIRE INVOLVED <input type="checkbox"/> OTHER		<input type="checkbox"/>
<input type="checkbox"/> PUBLIC		<input type="checkbox"/> FATAL <input type="checkbox"/> OTHER				<input type="checkbox"/>
2. PERSONAL DATA						
a. Name (Last, First, MI)		b. AGE	c. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		d. SOCIAL SECURITY NUMBER	
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				
3. GENERAL INFORMATION						
a. DATE OF ACCIDENT (month/day/year)		b. TIME OF ACCIDENT (Military time)		c. EXACT LOCATION OF ACCIDENT		d. CONTRACTOR'S NAME
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"/> DEPP <input type="checkbox"/> IRP <input type="checkbox"/> OTHER (Specify)		(1) PRIME: (2) SUBCONTRACTOR:
4. CONSTRUCTION ACTIVITIES ONLY (fill in line and corresponding code number in box from list - see help menu)						
a. CONSTRUCTION ACTIVITY (CODE)				b. TYPE OF CONSTRUCTION EQUIPMENT (CODE)		
INJURY/ILLNESS INFORMATION (include name on line and corresponding code number in box for items a, f & g - see help menu)						
a. VERITY OF ILLNESS/INJURY (CODE)				b. ESTIMATED DAYS LOST	c. ESTIMATED DAYS HOSPITALIZED	d. ESTIMATED DAYS RESTRICTED DUTY
e. BODY PART AFFECTED (CODE)				g. TYPE AND SOURCE OF INJURY/ILLNESS		
PRIMARY				TYPE		
SECONDARY				SOURCE		
f. NATURE OF ILLNESS / INJURY (CODE)						
6. PUBLIC FATALITY (fill in line and corresponding code number in box - see help menu)						
a. ACTIVITY AT TIME OF ACCIDENT (CODE)				b. PERSONAL FLOATATION 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	
<input type="checkbox"/> PICKUP/VAN <input type="checkbox"/> AUTOMOBILE <input type="checkbox"/> TRUCK <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)			USED NOT USED NOT AVAILABLE (1) FRONT SEAT (2) REAR SEAT	
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 corresponding code number in box from list - see help menu)						
a. TYPE OF VESSEL/FLOATING PLANT (CODE)				b. TYPE OF COLLISION/MISHAP (CODE)		
10. ACCIDENT DESCRIPTION (Use additional paper, if necessary)						
See attached page.						

11. CAUSAL FACTORS: (Brief description below Contributing)			
a. (Explain YES answers in item 13)	YES	NO	a. (CONTINUED)
DESIGN: Was design of facility, workplace or equipment a factor?	<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?
INSPECTION/MAINTENANCE: Were inspection & maintenance procedures a factor?	<input type="checkbox"/>	<input type="checkbox"/>	OFFICE FACTORS: Did office setting such as, lifting office furniture, carrying, stooping, etc., contribute to the accident?
PERSON'S PHYSICAL CONDITION: In your opinion, was the physical condition of the person a factor?	<input type="checkbox"/>	<input type="checkbox"/>	SUPPORT FACTORS: Were inappropriate tools/equipment provided to properly perform the activity/task?
OPERATING PROCEDURES: Were operating procedures a factor?	<input type="checkbox"/>	<input type="checkbox"/>	PERSONAL PROTECTIVE EQUIPMENT: Did the improper selection, use or maintenance of personal protective equipment contribute to the accident?
JOB PRACTICES: Were any job safety/health practices not followed when the accident occurred?	<input type="checkbox"/>	<input type="checkbox"/>	DRUGS/ALCOHOL: In your opinion, was drugs or alcohol a factor to the accident?
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"/>	b. WAS A WRITTEN JOB/ACTIVITY HAZARD ANALYSIS COMPLETED FOR TASK BEING PERFORMED AT TIME OF ACCIDENT?
			<input type="checkbox"/> YES // yes, attach a copy // <input type="checkbox"/> NO
12. TRAINING			
a. WAS PERSON TRAINED TO PERFORM ACTIVITY/TASK?	b. TYPE OF TRAINING.		c. DATE OF MOST RECENT FORMAL TRAINING.
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> CLASSROOM <input type="checkbox"/> ON JOB		(Month) (Day) (Year)
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 See attached page.			
b. INDIRECT CAUSE(S) See attached page.			
14. ACTIONS TAKEN, ANTICIPATED OR RECOMMENDED TO ELIMINATE CAUSE(S)			
DESCRIBE FULLY: See attached page.			
15. DATES FOR ACTIONS IDENTIFIED IN BLOCK 14.			
a. BEGINNING (Month/Day/Year)		b. ANTICIPATED COMPLETION (Month/Day/Year)	
c. SIGNATURE AND TITLE OF SUPERVISOR COMPLETING REPORT		d. DATE (M/D/Y)	e. ORGANIZATION IDENTIFIER (Div, B, Sect)
CORPS _____			f. OFFICE SYMBOL
CONTRACTOR _____			
16. MANAGEMENT REVIEW (1st)			
a. <input type="checkbox"/> CONCUR b. <input type="checkbox"/> NON CONCUR c. COMMENTS			
SIGNATURE		TITLE	DATE
17. MANAGEMENT REVIEW (2nd - Chief Operations, Construction, Engineering, etc.)			
a. <input type="checkbox"/> CONCUR b. <input type="checkbox"/> NON CONCUR c. COMMENTS			
SIGNATURE		TITLE	DATE
18. SAFETY AND OCCUPATIONAL HEALTH OFFICE REVIEW			
a. <input type="checkbox"/> CONCUR b. <input type="checkbox"/> NON CONCUR c. ADDITIONAL ACTIONS/COMMENTS			
SIGNATURE		TITLE	DATE
19. COMMAND APPROVAL			
COMMENTS			
COMMANDER SIGNATURE			DATE

10.

ACCIDENT DESCRIPTION (Continuation)

[Empty space for accident description]

13a.

DIRECT CAUSE (Continuation)

[Empty space for direct cause]

13b.

INDIRECT CAUSES (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 (including injured 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 boxes. If additional copies are 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 manager/reviewer indicated in sections 15 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 (loss, or fatality that requires the submission of OWCP Form CA-1 (Injury), CA-2 (Skeletal), or CA-3 (Fatality) to OWCP; mark if accident not noted in military personnel loss-unit or lost-pay or losses.
 - (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/losses 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 injury 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 its interests 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

2. **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.
3. **AGE** - Enter age.
4. **SEX** - Mark appropriate box.
5. **SOCIAL SECURITY NUMBER** - (FOR GOVERNMENT PERSONNEL ONLY) Enter the social security number (or other personal identification number if no social security number issued).
6. **GRADE** - (FOR GOVERNMENT PERSONNEL ONLY) Enter pay grade. Example: O-4; E-7; WG-8; WS-12; GS-11, etc.

7. **JOB DESCRIPTION** - For government civilian employees enter the pay plan, GS series number, and job title, e.g. GS-05 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.

8. **DUTY STATUS** - Mark the appropriate box
 - (1) **ON DUTY** - Person was at duty station during duty hour or person was away from duty station during duty hours but on official business at time of the accident.
 - (2) **TOV** - 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.
9. **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

4. **DATE OF ACCIDENT** - Enter the month, day, and year of accident.
5. **TIME OF ACCIDENT** - Enter the local time of accident in military time. Example: 1400 hrs (not 2:00 p.m.).
6. **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.).
7. **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.
8. **CONTRACT NUMBER** - Mark the appropriate box to identify if contract is civil work, military, or other. If "OTHER" is marked, specify contract appropriation on the provided. Enter complete contract number of prime contract, e.g. DACW 09-85-C-000.
9. **TYPE OF CONTRACT** - Mark appropriate box. A/E means architect/engineer, if "OTHER" is marked, specify type of contract on the provided.
10. **HAZARDOUS/TOXIC WASTE ACTIVITY (HTW)** - Mark the box to identify the HTW activity being performed at the time of the accident. For Superfund, DERR, and Installation Restoration Program (IRP) HTW activities include activities that occurred during site characterization, design, and construction. For the purpose of accident reporting, CERF Turnover 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

4. **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 | 14. ELECTRICAL |
| 2. SITE PREPARATION | 15. SCAFFOLDING/ACCESS |
| 3. EXCAVATION/TRENCHING | 16. MECHANICAL |
| 4. GRADING (EARTHWORK) | 17. PAINTING |
| 5. PIPING/UTILITIES | 18. EQUIPMENT MAINTENANCE |
| 6. FOUNDATION | 19. TUNNELING |
| 7. FORMING | 20. WAREHOUSING/STORAGE |
| 8. CONCRETE PLACEMENT | 21. PAVING |
| 9. STEEL ERECTION | 22. FENCING |
| 10. ROOFING | 23. SIGNING |
| 11. FRAMING | 24. LANDSCAPING/IRRIGATION |
| 12. MASONRY | 25. INSULATION |
| 13. CARPENTRY | 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 in the box. If equipment is not included below, use code 24, "OTHER", and write in specific type of equipment.

CONSTRUCTION EQUIPMENT

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

INSTRUCTIONS FOR SECTION 5-- INJURY/ILLNESS INFORMATION

a. SEVERITY OF INJURY / ILLNESS - Reference para 2-10 of USACE Suppl 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
- NRH 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	A8	ARM AND WRIST
	A9	ARM OR WRIST
TRUNK, EXTERNAL MUSCULATURE	B1	SINGLE BREAST
	B2	BOTH BREASTS
	B3	SINGLE TESTICLE
	B4	BOTH TESTICLES
	BA	ABDOMEN
	BC	CHEST
	BL	LOWER BACK
	BP	PENIS
	BS	SIDE
	BU	UPPER BACK
BW	WAIST	
BZ	TRUNK OTHER	
HEAD, INTERNAL	C1	SINGLE EAR INTERNAL
	C2	BOTH EARS INTERNAL
	C3	SINGLE EYE INTERNAL
	C4	BOTH EYES INTERNAL
	CB	BRAIN
	CC	CRANIAL BONES
	CD	TEETH
	CJ	JAW
CL	THROAT, LARYNX	
CM	MOUTH	

CM	NOSE	
CR	THROAT, OTHER	
CT	TONGUE	
UZ	HEAD OTHER INTERNAL	
ELBOW	EB	BOTH ELBOWS
	EE	SINGLE ELBOW
FINGER	F1	FIRST FINGER
	F2	BOTH FIRST FINGERS
	F3	SECOND FINGER
	F4	BOTH SECOND FINGERS
	F5	THIRD FINGER
	F6	BOTH THIRD FINGERS
	F7	FOURTH FINGER
	F8	BOTH FOURTH FINGERS
TOE	G1	GREAT TOE
	G2	BOTH GREAT TOES
	G3	TOE OTHER
	G4	TOES OTHER
HEAD, EXTERNAL	H1	EYE EXTERNAL
	H2	BOTH EYES EXTERNAL
	H3	EAR EXTERNAL
	H4	BOTH EARS EXTERNAL
	HC	CHIN
	HF	FACE
	HN	NECK/THROAT
	HM	MOUTH/LIPS
	HN	NOSE
	HS	SCALP
KNEE	K8	BOTH KNEES
	K9	KNEE
LEG, HP, ANGLE, BUTTOCK	L8	BOTH LEGS/HP/ ANKLES/BUTTOCKS
	L9	SINGLE LEG/HP/ ANKLE/BUTTOCK
HAND	M8	BOTH HANDS
	M9	SINGLE HAND
FOOT	P8	BOTH FEET
	P9	SINGLE FOOT
TRUNK, BONES	R1	SINGLE COLLAR BONE
	R2	BOTH COLLAR BONES
	R3	SHOULDER BLADE
	R4	BOTH SHOULDER BLADES
	R8	STERNUM (BREAST BONE)
	RY	VERTEBRAE (SPINE, BCC)
	RZ	TRUNK BONES OTHER
SHOULDER	S8	BOTH SHOULDERS
	S9	SINGLE SHOULDER
THUMB	T8	BOTH THUMBS
	T9	SINGLE THUMB
TRUNK, INTERNAL ORGANS	V1	LUNG, SINGLE
	V2	LUNGS, BOTH
	V3	KIDNEY, SINGLE
	V4	KIDNEYS, BOTH
	V4	HEART
	VL	LIVER
	V6	REPRODUCTIVE ORGANS
	V8	STOMACH
	VV	INTESTINES
	VZ	TRUNK, INTERNAL, OTHER

f. NATURE OF INJURY/ILLNESS - Select the most appropriate nature of injury / illness from the list below. The nature of injury / illness also correspond to the primary body part affected in 5a, above. Enter the nature of injury / illness name on the line and place the corresponding CODE letter in the box provided.

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

GENERAL NATURE CATEGORY	CODE	NATURE OF INJURY NAME
TRAUMATIC INJURY OR DISABILITY	TA	AUFFRACTION
	TB	BACK STRAIN
	TC	CONTUSION; BRUISE
	TD	ABRASION
	TE	DISLOCATION
	TF	FRACTURE
	TH	HEMIA
	TK	CONCUSSION
	TL	LACERATION, CUT
	TP	PUNCTURE
	TS	STRAIN, MULTIPLE
	TU	BURN, SCALD, SUNBURN
	TI	TRAUMATIC SKIN DISEASES/ CONDITIONS INCLUDING DEBRITING
	TR	TRAUMATIC RESPIRATORY DISEASE
	TD	TRAUMATIC FOOD POISONING
	TR	TRAUMATIC TUBERCULOSIS
	TK	TRAUMATIC VIROLOGICAL/ INFECTIVE/ PARASITIC DISEASE
	TI	TRAUMATIC CEREBRAL VASCULAR CONDITION/STROKE
TJ	TRAUMATIC HEARING LOSS	
TK	TRAUMATIC HEART CONDITION	
TK	TRAUMATIC MENTAL DISORDER/ STRESS, NERVOUS CONDITION	
TR	TRAUMATIC INJURY - OTHER (EXCEPT DISEASE, ALLERGIC)	

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

GENERAL NATURE CATEGORY	CODE	NATURE OF INJURY NAME
NONTRAUMATIC ILLNESS/DISEASE OR DISABILITY		
RESPIRATORY DISEASE	RA	ASBESTOSIS
	RB	BRONCHITIS
	RE	EMPHYSEMA
	RF	PNEUMOCOCCUS
	RG	SILICOSIS
	RA	RESPIRATORY DISEASE, OTHER
VIROLOGICAL, INFECTIVE & PARASITIC DISEASES	VB	BRUCELLOSIS
	VC	COCOSIDIOSIS
	VF	FOOD POISONING
	VI	HEPATITIS
	VM	MALARIA
	VE	STAPHYLOCOCCUS
VT	TUBERCULOSIS	
VS	VIROLOGICAL/INFECTIVE/ PARASITIC - OTHER	
DISABILITY, OCCUPATIONAL	DA	ARTHRITIS, SUPRATIS
	DB	BACK STRAIN, BACK SPRAIN
	DC	CEREBRAL VASCULAR CONDITION/ STROKE
	DD	ENDANG DISEASE (OTHER THAN CODE TYPE RAB)
	DE	EFFECT OF ENVIRONMENTAL CONDITION
	DH	HEARING LOSS
	DK	HEART CONDITION
	DM	MENTAL DISORDER, EMOTIONAL STRESS, NERVOUS CONDITION
	DN	RADIATION
	DS	STRAIN, MULTIPLE
	DU	ULCER
	DV	OTHER VASCULAR CONDITIONS
	DA	DISABILITY, OTHER

GENERAL NATURE CATEGORY	CODE	NATURE OF INJURY NAME
SKIN DISEASE OR CONDITION	SB	BIOLOGICAL
	SC	CHEMICAL
	SD	DERMATITIS, UNCLASSIFIED

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 slipped on carpet and struck his hand on a desk.
TYPE: 210 (fall on same level) SOURCE: 0110 (working/walking surface)

NOTE: This example does NOT become 20 (travelling against a motion point).

(2) A Fork Loader operated backwards from contact with poison ivy oak.
TYPE: 310 (contact) SOURCE: 0820 (plant)

(3) A lock and dim mechanic punctured his finger with a metal silver while polishing a drilled blade.
TYPE: 410 (projected by) SOURCE: 0830 (metal)

(4) An employee was driving a government vehicle when it was struck by another vehicle.
TYPE: 600 (travelling in) SOURCE: 0421 (government-owned vehicle, no driver)

NOTE: The Type Code 600, "travelling in" is different from the other type codes in that it applies to all persons (while travelling in the injury or health, but only to vehicles) on the type of source the employee was operating or travelling in at the time of the event.

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
010	STRUCK BY
011	STRUCK BY FALLING OBJECT
020	STRUCK AGAINST
021	FELL, SLIPPED, TRIPPED
022	FELL ON SAME LEVEL
023	FELL ON DIFFERENT LEVEL
024	SLIPPED, TRIPPED (NO FALL)
030	CAUGHT
031	CAUGHT ON
032	CAUGHT IN
033	CAUGHT BETWEEN
040	PUNCTURED, LACERATED
041	PUNCTURED BY
042	CUT BY
043	STUCK BY
044	BITTEN BY
050	CONTACTED
051	CONTACTED BY (DRAPED PERSON MOVING)
052	CONTACTED BY (OBJECT WAS MOVING)
060	EXERTED
061	LIFTED, STRAINED BY (SINGLE ACTION)
062	STRESSED BY (REPEATED ACTION)
070	EXPOSED
071	INHALED
072	INGESTED
073	ABSORBED
074	EXPOSED TO
080	TRAVELING IN
090	SOURCE OF INJURY NAME
010	BUILDING OR WORKING AREA
011	WALKING/WORKING SURFACE (FLOOR, STREET, SIDEWALK, ETC)
020	STAIRS, STEPS
030	LADDER
040	FURNITURE, FURNISHINGS, OFFICE EQUIPMENT
050	BOILER, PRESSURE VESSEL
060	EQUIPMENT LAYOUT (ERGONOMIC)
070	WINDOWS, DOORS
080	ELECTRICITY

0008 SOURCE OF INJURY NAME

0090 ENVIRONMENTAL CONDITION

0091 TEMPERATURE EXTREMES (INDOOR)

0092 WEATHER (ICE, RAIN, HEAT, ETC.)

0093 FIRE, FLAME, SMOKE (NOT TOBACCO)

0094 NOISE

0095 RADIATION

0096 LIGHT

0097 VENTILATION

0098 TOBACCO SMOKE

0099 STRESS (EMOTIONAL)

0100 CONFINED SPACE

0101 MACHINE OR TOOL

0102 HAND TOOL (POWERED; SAW, SHEDDER, ETC.)

0103 HAND TOOL (UNPOWERED)

0104 MECHANICAL POWER TRANSMISSION APPARATUS

0105 GUARD, SHIELD (FIXED, MOVABLE, INTERLOCK)

0106 VIDEO DISPLAY TERMINAL

0107 PUMP, COMPRESSOR, AIR PRESSURE TOOL

0108 HEATING EQUIPMENT

0109 WELDING EQUIPMENT

0110 VEHICLE

0111 AS DRIVER OF PRIVATELY OWNED/RENTAL VEHICLE

0112 AS PASSENGER OF PRIVATELY OWNED/RENTAL VEHICLE

0113 DRIVER OF GOVERNMENT VEHICLE

0114 PASSENGER OF GOVERNMENT VEHICLE

0115 COMMON CARRIER (AIRLINE, BUS, ETC.)

0116 AIRCRAFT (NOT COMMERCIAL)

0117 BOAT, SHIP, BARGE

0118 MATERIAL HANDLING EQUIPMENT

0119 EARTHMOVER (TRACTOR, BACKHOE, ETC.)

0120 CONVEYOR (FOR MATERIAL AND EQUIPMENT)

0121 ELEVATOR, ESCALATOR, PERSONNEL HOIST

0122 HOIST, SLING CHAIN, JACK

0123 CRANE

0124 FORKLIFT

0125 HANDTRUCK, DOLLY

0126 DUST, VAPOR, ETC.

0127 DUST (SILICA, COAL, ETC.)

0128 FIBERS

0129 ASBESTOS

0130 GASES

0131 CARBON MONOXIDE

0132 MIST, STEAM, VAPOR, FUME

0133 WELDING FUMES

0134 PARTICLES (NON-ENTRAGED)

0135 CHEMICAL, PLASTIC, ETC.

0136 DRY CHEMICAL—CORROSIVE

0137 DRY CHEMICAL—TOXIC

0138 DRY CHEMICAL—EXPLOSIVE

0139 DRY CHEMICAL—FLAMMABLE

0140 LIQUID CHEMICAL—CORROSIVE

0141 LIQUID CHEMICAL—TOXIC

0142 LIQUID CHEMICAL—EXPLOSIVE

0143 LIQUID CHEMICAL—FLAMMABLE

0144 PLASTIC

0145 WATER

0146 MEDICINE

0147 INAPPROPRIATE OBJECT

0148 BOX, BARREL, ETC.

0149 PAPER

0150 METAL ITEM, MINERAL

0151 NEEDLE

0152 GLASS

0153 SCRAP TRASH

0154 WOOD

0155 FOOD

0156 CLOTHING, APPAREL, SHOES

0157 ANIMATE OBJECT

0158 DOG

0159 OTHER ANIMAL

0160 PLANT

0161 INSECT

0162 HUMAN (VIOLENCE)

0163 HUMAN (COMMUNICABLE DISEASE)

0164 BACTERIA, VIRUS (NOT HUMAN CONTACT)

0008 SOURCE OF INJURY NAME

1000 PERSONAL PROTECTIVE EQUIPMENT

1001 PROTECTIVE CLOTHING, SHOES, GLASSES, GOGGLES

1002 RESPIRATOR, MASK

1003 DIVING EQUIPMENT

1004 SAFETY BELT, HARNESS

1005 PARACHUTE

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 this line and the corresponding number in the box. If the activity performed is not specified in 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. Boating | 8. Swimming (designated area) |
| 2. Boating—general | 10. Swimming (general area) |
| 3. Boating—unpowered | 11. Unathletic activities (golf, skiing, hiking, etc.) |
| 4. Water skiing | 12. Fishing |
| 5. Floating (raft, boat) | 13. Attempted rescue |
| 6. Floating (non-raft, boat or pier) | 14. Floating (raft, boat) |
| 7. Floating (water skiing) | 15. Other |
| 8. Swimming (designated area) | |

NON-WATER RELATED RECREATION

- | | |
|--|---|
| 16. Hiking and walking | 23. Sports/summer (baseball, basketball, etc.) |
| 17. Climbing (general) | 24. Sports/winter (skiing, skating, snowmobiling, etc.) |
| 18. Canyoning (authorized authorized area) | 25. Cycling (bicycle, motorcycle, scooter) |
| 19. Canyoning (unauthorized area) | 26. DRIVING |
| 20. Guided tour | 27. Parachuting |
| 21. Hunting | 28. Other non-water related |
| 22. Playground equipment | |

OTHER ACTIVITIES

- | | |
|---|---------------------------------|
| 29. Unlisted activity (include name, description, etc.) | 35. Shopping |
| 30. Food preparation/cooking | 36. Recreation (not by vehicle) |
| 31. Food consumption | 37. Feeding other person |
| 32. Housekeeping | 38. Suicide |
| | 39. Other activities |

b. **PERSONAL FLOTATION DEVICE USED**—If fatality was water-related was the victim wearing a personal 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 types in the appropriate box. USADE vehicle(s) involved shall be indicated 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/ownership distributed 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 | 7. DREDGESHIPPER |
| 2. SWL BOAT | 8. DREDGE/CLASHHELL BUCKET |
| 3. MOTOR BOAT | 9. DREDGEPIPE LINE |
| 4. RAFFLE | 10. DREDGE/BOUST PAN |
| 5. DREDGEHOPPER | 11. TUG BOAT |
| 6. DREDGE/SHOPE CASTING | 12. OTHER |

B. COLLISION/SHIP—Select from the list below the object(s) that contributed to the accident or were damaged in the accident.

COLLISION/SHIP

- | | |
|-----------------------------|-----------------------------|
| 1. COLLISION WITH/IN VESSEL | 7. HULLAGE UNIT |
| 2. UPPER GUIDE WALL | 8. BREAKING TOW |
| 3. UPPER LOCK GATES | 9. ROW BREAKING UP |
| 4. LOCK WALL | 10. SWEPT DOWN ON DAM |
| 5. LOWER LOCK GATES | 11. BUDY/DOCK/PIERCING CELL |
| 6. LOWER GUIDE WALL | 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 roles in the accident. Describe the 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 inadequacy or improperly maintained equipment, tools, work areas, 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 and/or workload 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, wind, heat, sun, temperature changes, wind, noise, fumes, odors, dust, dirt, heat, 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, fumes (aerosols, etc.), acids, bases (caustic materials, chlorides, etc.), mists, vapors, fumes, gases, smoke, other particulates, liquid or dry chemicals that are explosive, toxic, corrosive 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?

(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 filling 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 allowed 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-hat, 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 performed 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 this 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 healthy 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 the month, day, and year 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 led 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:

1. Employee was dismantling scaffold and fell 12 feet from unguarded opening.
Direct cause: failure to provide fall protection at elevation.
Indirect cause: failure to enforce USACE safety requirements; improper reconfiguration of employee; possibility that employee was not knowledgeable of USACE fall protection requirements or was lax in his attitude toward safety; failure to assure provision of positive fall protection whenever elevated; failure to address fall protection during scaffold dismantling in phase hazard analysis.
2. 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 appropriate 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 in the actions taken, anticipated, and recommended to eliminate the cause(s) and prevent recurrence of similar accidents/incidents. Confine to plain simple of paper if necessary to fully explain and attach to the completed report form.

INSTRUCTIONS FOR SECTION 15 -- DATES FOR ACTION

- a. **BEGN DATE**-- Enter the date when the corrective action(s) identified in Section 14 will begin.
- b. **COMPLETE DATE**-- Enter the date when the corrective action(s) identified in Section 14 will be completed.
- c. **TITLE AND SIGNATURE**-- Enter the title and signature of supervisor completing the accident report. For a GOVERNMENT employee accident/loss the immediate supervisor will complete and sign the report. For PUBLIC accidents the USACE Project Manager/Key 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 by 15.d, 15.a and 15.f below, the responsible USACE supervisor shall forward the report for management review as indicated in Section 16.
- d. **DATE SIGNED**-- Enter the month, day, and year that the report was signed by the responsible supervisor.
- e. **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 15.c. For CONTRACTOR accidents enter the USACE organization name for the USACE office responsible for providing contract administration oversight.

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

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 15.c 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 discrepancies, 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.

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Accident Reporting Requirements

1. References:

- a. AR 385-40, Accident Reporting, 1 November 1994
- b. U.S. Army Corps of Engineer (USACE) Draft Supplement 1 to AR 385-40, 5 October 2000
- c. USASC Message, CSSC-Z, 081810Z Jun 01, subject: Clarification of Army Accident Classes
- d. CEHNCR 385-1-1, Safety and Occupational Health Program Management, 19 June 1997
- e. EM 385-1-1, U.S. Army Corps of Engineers Safety Manual, 03 November 2003

2. Accident Definitions:

- a. Class A - Fatality or permanent total disability (Government Civilian, Military Personnel, and/or Contractor), or > \$1,000,000 property damage*.
- b. Class B - Permanent partial disability or inpatient hospitalization of 3 or more persons (Government Civilian, Military Personnel, and/or Contractor), $\$200,000 \leq \$1,000,000$ property damage*.
- c. Class C - Lost Workday (Contractor) or Lost Time (Government Civilian and Military Personnel), $\$20,000 \leq \$200,000$ property damage*.
- d. Class D - $\$2000 \leq \$20,000$ property damage*.

*Property damage examples - rental cars, leased items/equipment, GSA property, Huntsville Center (HNC) property, installation property, land owner property.

3. All accidents meeting the definitions above, both contractor and government civilian, are to be reported immediately. Government civilian accidents are to be reported to the first line supervisor; for contractor accidents, either the project manager (PM), contracting officer (KO), contracting officer representative (COR) and/or resident engineer (RE) herein referred to as the "Government Designated Authority (GDA)", who by position is responsible for overseeing, managing, directing, and/or administering the project/activity, operation, material

or person(s) involved at the time of an accident. The supervisor or GDA upon learning of an accident must promptly contact the CEHNC Safety Office and provide a brief summary of the events surrounding the accident. The Safety Office will notify the Command Group.

4. In addition to the accidents described in paragraph 2, the following conditions must also be reported per the guidance outlined in paragraph 3.

a. Army civilian or contractor personnel injured while on duty or on TDY status. Exception: Contractor employee injuries, occupational illnesses, and property damage accidents that occur away from, and involve activities unrelated to, a Corps project/activity for which the contractor is working, are not required to be reported.

b. Accidents or mishaps incident to a Corps project/activity that could cause embarrassment to USACE.

c. Serious near misses.

d. Injuries to CEHNC military personnel, on or off-duty.

e. Medical expenses incurred by government civilians regardless of whether or not the injury meets one of the accident definitions above.

5. For government civilian accidents the supervisor is responsible for investigating the accident. For contractor accidents occurring incident to a CEHNC project/activity, the contractor is responsible for performing the accident investigation in accordance with the contractor's accepted Accident Prevention Plan (APP). The investigation is the supervisor's or contractor's documented internal review, analysis and account of the accident, based on factual information gathered by a thorough and conscientious examination of all causal factors. Its purpose is PREVENTION. Therefore, it is essential for the supervisor or contractor to take positive measures and any necessary corrective actions to prevent future occurrences. At the conclusion of the investigation, the supervisor or contractor must submit a completed original ENG Form 3394, with its instructions to the CEHNC Safety Office for review and processing within 5 working days following the accident. A copy of the ENG Form 3394 can be found at:

<http://www.hnd.usace.army.mil/engdir/organization/systems-eng/Safety/safety2.htm>

This form must be routed through the appropriate Director's office for review and signature prior to submitting to the Safety Office.

5 April 2004

6. On the original ENG Form 3394, if block 11b is checked "Yes," the job/activity hazard analysis for the task/activity being performed at the time of the accident must be submitted as an attachment. If the block is checked "No," and the accident is on a project/activity for which EM 385-1-1, Corps Safety Manual is applicable, an activity hazard analysis must be developed and submitted to the CEHNC Safety Office for review and acceptance prior to resuming the specific work activity being performed at the time of the accident. The CEHNC Safety Office will assess the adequacy of the investigation as described in the ENG Form 3394 along with all submitted analyses to determine whether the information provided is acceptable. If the investigation report is found acceptable, the Safety Office will notify the supervisor or GDA that the specific work activity may resume.

7. For government civilian claims, all Class A through C accidents require the submission of a Department of Labor (DOL) Form CA-1 (injury), CA-2 (illness/disease/stress) or CA-6 (fatality) in addition to the ENG Form 3394. Please note that a CA-1 or CA-2 is a mandatory submission if medical expenses are incurred. The employee is responsible for completing and submitting the appropriate form to their immediate supervisor for processing. The supervisor is responsible for reviewing, signing and delivering the form to the CEHNC Safety Office for processing. The CA-1 and CA-2 forms are time sensitive and must be submitted within 15 working days from the date of the accident. A timely submission will ensure the forms reach the Office of Workers' Compensation Program (OWCP) administrator as required and expedites the judicious payment of expenses incurred. In the unlikely event a fatality should occur, please call the Safety Office immediately.

8. If assistance is needed in reporting or investigating accidents, please contact the undersigned at 256-895-1583 or Greg Bayuga, 256-895-1596. Completed sample forms are available in the Safety Office.

/s/
CHARLES R. (RAY) WAITS, JR.
Chief, Safety and Occupational
Health Office

DISTRIBUTION:

A & B (Branch Level)
CEHNC-SO (Williams, Bayuga, Plyler, Taylor, Griffin, Sawyers)

ACCIDENT REPORT FOLLOW-UP FORM

To be used to supplement the online Parsons Accident Reporting Tool. Maintain a copy of this record in the project files in the Parsons field office.

Employee: _____

Date of Injury or Illness: _____

ANALYSIS – What caused the accident. Why did it happen:

Primary Cause:

Contributing Factors:

PREVENTIVE/CORRECTIVE ACTION – State what will be done to prevent reoccurrence:

Immediate Action:

Who is responsible: _____ Completion Date(s): _____

Long-Term Action:

Who is responsible: _____ Completion Date(s): _____

Closed by: _____
Facility Health and Safety Representative *Date*
