

**SOUTH CAROLINA COUNTIES WORKERS' COMPENSATION TRUST  
ACCIDENT INVESTIGATION FORM**

1. Member:	2. Employee Name:
3. Department:	4. Exact Location:
5. Date and Time of Accident:	6. Date Reported:
7. Please describe clearly how the accident occurred:	

**CONTINUED ON NEXT PAGE**

DIRECT CAUSES		BASIC CAUSES	
UNSAFE ACTS	UNSAFE CONDITIONS	WORK SYSTEM	
Lack of skill or knowledge	Inadequate guards or protection		Inadequate hiring/placement practices
Failure to follow operating or maintenance procedure/method	Defective tools, equipment, machine or vehicle		Inadequate enforcement of work rules and procedures
Failure to use guards provided	Congested work area/roadways		Inadequate job instruction/training
Failure to use personal protective equipment	Unsafe floors, ramps, stairways, platforms		Inadequate safety procedures
Making safety devices inoperable	Poor housekeeping		Inadequate preventive maintenance
Operating vehicle, equipment or machine at unsafe speed or in an unsafe manner	Hazardous atmosphere: gases, dust, fumes, vapors		Inadequate environmental control program
Using known defective equipment	Hazardous chemicals/substances		Inadequate job planning methods
Operating without authority	Inadequate warning system		Improper layout or design of work area
Improper lifting, lowering or carrying technique	Fire or explosion hazards		Unsafe design or construction of tools, equipment or machine
Taking unsafe position	Improper material storage		Inadequate medical monitoring
Influence of alcohol or drugs	Inadequate ventilation		Inadequate supervision
Physical or mental limitations	Excessive noise		Other—explain in detail
Unaware of hazards	Inadequate illumination		
Unsafe act of non-employee	Poor road conditions	<b>INDIVIDUAL</b>	
Other—explain in detail	Limited visibility		Pre-existing physical condition
	Adverse weather		Physical impairment due to drug use
	Other—explain in detail		Employee insubordination or dishonesty

9. What actions have been or will be taken to remove Direct Causes? List all items in sequence:	By Whom:	When:
10. What actions have been taken to remove the Basic Causes? List steps that will be taken to remove the Basic Causes to help prevent similar accidents in the future.	By Whom:	When:

**If the employee was injured in a motor vehicle accident, please complete the below  
Motor Vehicle Accident Investigation Supplement**

Employee/driver name:		Department:	
Vehicle make/model/year:		Vehicle mileage:	
Did police report state that employee contributed to the accident? Yes                      No	Was employee cited?    Yes              No If yes, which violation was cited?		
Was employee drug tested?    Yes              No	Was employee wearing a seat belt?    Yes              No		
How could the employee have avoided the accident?	Did the employee receive sanctions? If yes, list sanctions:		
Has this employee had previous motor vehicle accidents in county vehicles? Yes              No If yes, please describe briefly.		When was the last motor vehicle record reviewed for this driver?	
Has this employee taken a defensive driving class? If yes, what was the name of the class and when was it taken?			

Investigated By: \_\_\_\_\_ Date: \_\_\_\_\_