Badger Swimpools, Inc. Incident/Injury/Illness Investigation Report

Location of Incident/Injury/Illness (Supervisor Section) **OSHA CASE #:**

Facility:	City, State:	Department, Machine or Area:

Employee Information (Supervisor Section)

Name: (last, first)	SS#:	Department:
Home Address:	Date of Birth:	Occupation:
	Home Phone:	Job when injured:

Incident/Injury/Illness Information (Supervisor Section)

Incident Date:	Report Date:	Type of Illness/Injury/Body Part:	
Incident Time:	Report Time:	Doctor/Hospital:	
Description of Incident: (explain how occurred, people, equipment, process):			
Time Shift Began:	Emergency Room Treatment? Yes No	Hospitalized Overnight? Yes No	Witnesses:

Employee Statement of Facts (Employee fills out this section; include signed and dated attachments as necessary)

1. Please provide a step by step description of this incident, including what you were doing just before it happened.
2. Please describe, in detail, any personal injury/illness that resulted from this incident and any medical treatment including medications received.
3. Describe the status or condition of any work surface, tool, equipment or other physical element involved in this accident.
4. Describe the location of the accident.
5. Please state how you might have kept this incident from occurring.
6. Please state what you think the company can do to help protect against a repeat occurrence of this type incident.
7. **Medical Release Authorization:** I hereby authorize Badger Swimpools to be furnished any information and facts regarding this injury (or illness), including reports and records, diagnosis, treatment, prognosis, estimates of disability and recommendations for further treatment. This information is to be used for the purpose of handling my claim.

Employee Signature:	Date:

Badger Swimpools, Inc.

Supervisor's Accident Cause Analysis

Cause and Prevention Analysis (Include Supervisor Signed and Dated Attachments As Necessary)

Person Injured / Illness : As Applicable	yes	no	n/a		Working Conditions : As Applicable	yes	no	n/a
♦ Unsafe acts / practices					♦ Normal routine conditions			
♦ Lack of safety awareness					♦ Normal, Non-routine conditions			
♦ Lack of proper training					♦ Abnormal conditions			
♦ Was judgment a factor?					♦ Employee created unsafe conditions			
♦ Not following proper procedure / practice					♦ Unsafe working conditions			
♦ Lack of proper supervision					♦ Not a factor			
♦ Other (explain below)					♦ Other (explain below)			
Other Persons Involved / Witnesses : As Applicable					**Equipment or Facility : As Applicable**			
♦ Unsafe acts / practices					♦ Employee did not recognize hazard			
♦ Lack of proper training					♦ Recognized hazard - no action taken			
♦ Was judgment a factor?					♦ Hazardous design factor			
♦ Lack of experience					♦ Hazardous installation factor			
♦ Not following proper procedure / practice					♦ Improper Use of equipment			
♦ Acceptance of unsafe practice / condition					♦ Inadequately maintained equipment			
♦ Lack of proper supervision					♦ Wrong equipment used			
♦ Not a factor					♦ Not a factor			
♦ Witnesses? (Attach signed statements)					♦ Other (explain below)			
Job Procedures – Are they :					**Job Procedures – Are they : *(con't.)***			
♦ Adequate for the job					♦ Written procedures available			
♦ Understood by employees					♦ Safety Issues / Training Documented			
♦ JSA has been covered with employees					♦ Other (explain below)			

Cause(s): (consider people, actions, procedures, training, supervision, equipment, and facility conditions)

Action(s) Taken To Prevent Recurrence: (consider injured employee(s), other employee(s), procedures, training, equip)
Give Completion Dates for Action Plans: (provide specific action plans and respective dates)

Foreman Signature:	Date:	Comments / Concerns:
Operations Manager Signature:	Date:	Comments / Concerns:
Human Resources Manager Signature:	Date:	Comments / Concerns:

Workers' Compensation Reporting (Completed by HR/Medical/Supervisor or Manager)

Male Female	Employee Classification:	Length of Service:	Average Hours per Day:
Marital Status: # Dependents:	Shift:	Time on Present Job:	Average Days per Week:
Substance Abuse Testing? Yes No	Reason for OSHA recording or non-recording:	Date of Hire:	Corrective Action? No Yes N/A

Badger Swimpools

CONSTRUCTING INNOVATIVE AQUATIC FACILITIES

ACCIDENT REPORT
BODY PART CHART

Employee Name ____

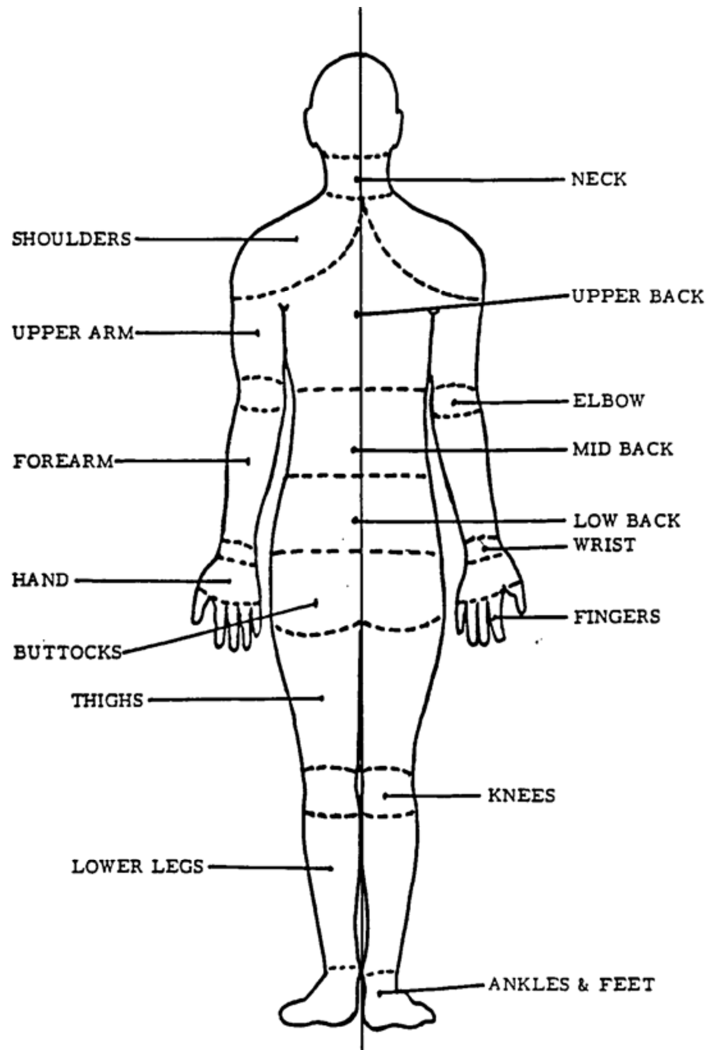
Date of Accident ________________ Date of Report _______________

Employee's Signature ____

Reported by ____

DIRECTIONS: Mark the Injured Body Part & have the Employee Initial by the mark.

Left Side Right Side



BACK VIEW

BADGER SWIMPOOLS, INC.

WITNESS STATEMENT OF ACCIDENT

Witness Name: ______________________________ Today's Date: ______________________

Supervisor's Name: ______________________________ Department: ______________________

Injured Employee: ______________________________ Date of Accident: ______________________

State in your own words what you saw: ____________________________________

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Witness's Signature: ____________________________________ Date: ______________

CONSENT AND MEDICAL INFORMATION AUTHORIZATION

I consent and request that Badger Swimpools, their insurance carrier, any agent, or anyone acting on their behalf or their assigns, be permitted to examine and obtain copies of all hospital, medical, educational, and vocational records of every sort and kind, review records of any insurance company, interview all doctors, rehabilitation professionals, vendors and all employers and former employers regarding all matters relating to examination, diagnosis, care and treatment, planning, earnings and loss of earnings of either myself, my child or ward.

I further authorize the disclosure of any information obtained pursuant to this authorization to attorneys or licensed physicians retained by the insurance carrier in evaluation of claims made by me, my child or ward.

This authorization is for the purpose of providing necessary information on my claim resulting from an occurrence and is valid until the date the claim is settled, not to exceed three years from today's date.

A photostatic copy of this authorization is to be given the same force and effect as the original. I know that I may request to receive a copy of this authorization.

Witness______________________________ Signed _______________________________________

Witness______________________________ Date ____

Address ____

____

Home phone ______________________________________

Work phone ______________________________________

SSN ____

Authorization for Medical Treatment

Employee ____ **Date**_______________
Doctor ____ **Time**_______________

*Any Badger Swimpool employee receiving treatment or examination for a work-related injury/illness **must present this form to the treating physician for completion** or payment for treatment may be delayed. (In an emergency situation this form can be completed after receiving treatment, then returned to the Company.)*

*Any Badger Swimpool employee **must return** to the Company after the first treatment or subsequent treatments on scheduled workdays.*

NOTICE TO PHYSICIANS
*We expect the best medical treatment and care you can provide for our employees. **We authorize treatment deemed reasonable, necessary and causally-related to our employee's work-related injury**. We also want them to return to work as soon as possible so they can continue to receive full wages and to help us maintain continued efficiency.*

*We **believe**, as do many in the medical profession, that getting the employee back to work is the best rehabilitation treatment we can provide, in most cases. We recognize this depends on their physical limitations, if any, and the jobs that are available. We make every effort to offer temporary alternate work for our employees, tailored to their restrictions set by you. **Please complete this form to assist us with placing our employee in Badger Swimpool's Return-to-Work Program**.*

____
Manager or Human Resource Mgr. Date

PLEASE COMPLETE THE FOLLOWING INFORMATION BELOW:
POST ACCIDENT DRUG SCREEN: ___BREATH ALCOHOL-All Employees

DIAGNOSIS: ____

1. Is employee able to return to work?
   a. Full Duty ______
   b. Restricted Duty_____
   c. Total Disability _____
2. If restricted duty at **work and home**, please **describe restrictions** and state how long?
   ____
   ____
3. Will employee need follow-up treatment? **Yes ________ No**
4. If *Yes*, when? **Date _______ Time _______ Approximate # times** ______
5. Approximate duration of disability _____day/s____week/s____month/s
   Comments ____

____
Physician Signature **Date** **Time**

Essential Job Functions – Form E

Employee job title:	Date:
Personal Protective Equipment (ex. Earplugs, etc):	Work hours:
	Location:

Job Physical Demands Survey

Mark the appropriate box for each of the following items to describe the extent to which the specific activity can be performed:

M/E	Activity	Frequency					M/E	Activity	Frequency				
		N	O	F	C	Hr/ Min			N	O	F	C	Hr/Min
	Lift/Carry							Bend					
	10 lbs or less							Kneel					
	10-20 lbs							Twist/Turn					
	21-50 lbs							Climb					
	51-100 lbs							Crawl					
	100+ lbs							Reach Above Shoulder					
								Reach Outward					
	Push/Pull Force							Reach Below Knee					
	12 lbs or less							Stand					
	13-25 lbs							Walk					
	26-40 lbs							Sit					
	41-100 lbs							Balance					
								Squat					
	Drive							Crouch					
	Automatic							Awkward Position					
	Standard							Handling/Fingering					
	Foot Controls							Forceful Grip					
	Hand Controls							Pinching					
								Grasping					
	Office							Flexing Wrist					
	Keyboard												
	Static Position							Environmental					
								Heat					
	Tools							Cold					
	Small Hand							Noise					
	Power							Chemical					
	Driver/Hand Torque												

Key: M=Marginal E=Essential N=Never O=Occasional (1-33% of time) F=Frequent (34-66% of time) C=Constant (67-100% of time)

Physicians Return to Work – Form E

After treating this employee, please complete this form and give it to our employee to return to the Injury Coodinator. Thank you.

Injured Employee:	Date:
Injury Coordinator:	Physician
Diagnosis:	

Job Physical Demands Survey

Mark the appropriate box for each of the following items to describe the extent to which the specific activity can be performed:

M/E	Activity	Frequency					M/E	Activity	Frequency				
		N	O	F	C	Hr/ Min			N	O	F	C	Hr/Min
	Lift/Carry							Bend					
	10 lbs or less							Kneel					
	10-20 lbs							Twist/Turn					
	21-50 lbs							Climb					
	51-100 lbs							Crawl					
	100+ lbs							Reach Above Shoulder					
								Reach Outward					
	Push/Pull Force							Reach Below Knee					
	12 lbs or less							Stand					
	13-25 lbs							Walk					
	26-40 lbs							Sit					
	41-100 lbs							Balance					
								Squat					
	Drive							Crouch					
	Automatic							Awkward Position					
	Standard							Handling/Fingering					
	Foot Controls							Forceful Grip					
	Hand Controls							Pinching					
								Grasping					
	Office							Flexing Wrist					
	Keyboard												
	Static Position							Environmental					
								Heat					
	Tools							Cold					
	Small Hand							Noise					
	Power							Chemical					
	Driver/Hand Torque												

Key: M=Marginal E=Essential N=Never O=Occasional (1-33% of time) F=Frequent (34-66% of time) C=Constant (67-100% of time)

Medical Treatment Waiver

Date_______________________

I __________________________________, do not wish to seek medical treatment at this time for my work-related injury that occurred on___________________________. I also understand that should I decide at a later time to seek medical treatment, I must first attain a signed Treatment Authorization Form from a member of the management team at Badger Swimpools.

Signed______________________________________

Manager___________________________________