ACCIDENT NOTIFICATION FEEDER REPORT

Safety Office Use Only	Date Received:	Time Received:
PAN/OSHA 300 Report Reference #:		

WHEN

Date of Accident:		Time of Accident:		Day of Accident:	

OR

From:		To:	

WHERE

Division/Center:	SWD-Southwestern Division	District/Lab/Other:	
City:		State:	
Exact Location of The Accident:			
Project:		Contract Number:	

WHO

Number of People Involved:	Number of Properties:

EVENT

3 or More Government/Contractor Employees Hospitalized?	

Summary of Accident

Remarks

Describe Any Information Released To The Public

Point of Contact

Point of Contact Name:			
Job Title:		Job Series:	

Prepared By

Name:	Phone:	Date:
Signature:	SIGNATURE IS NOT REQUIRED	

People Involved

Last Name:		First Name:		Middle Init:	
Address:		City:		Country:	United States
		State:	Texas	Zip Code:	
Gender:		Date of Birth:		Person Type:	
Age:		Last Four SSN#:		Job Series:	
Contract Number:		Primary Contractor:		Sub Contractor:	
Primary Language:		Job Title:		Date Hired:	
Duty Status:		Post Status:			
FOA:		Office Symbol: CESWG -			
Unit and Station Assignment:					

Safety Equipment and Individual Training

Personal Protective Equipment	Available?	Used?
Check Appropriate Block(s)		
☐ Seat Belt	☐	☐
☐ Restraint System	☐	☐
☐ Goggles/Glasses/Visor	☐	☐
☐ Gloves	☐	☐
☐ Ear Plugs	☐	☐
☐ IBA	☐	☐
☐ Other (Specify)	☐	☐
☐ Helmet/Hardhat	☐	☐
DOT Approved (if Motorcycle)? Yes ☐ No ☐		

Alcohol/Drugs Caused or Contributed
Yes ☐ BAC% ____ No ☐ Unknown ☐

Licensed to operate equipment involved?

Mandatory 4hr Traffic Safety Training Received?
Yes ☐ No ☐ If Yes, Date Received: _____

Duty Hours

a. Time Work Began (e.g., 0645):
b. Continuous Hours Worked:

Hours of Sleep in the Last 24 Hours?

Tactical Training?

Type of Training Facility?

Last Training Received?

Injury /Illness

Injury/Illness:	
Severity of Injury/Illness:	
Injury/Illness Type:	
Nature of Injury/Illness:	
General Body Area:	
Specific Body Part:	
Source of Injury:	
If the Employee Died, when did Death Occur?	

Recreation Information		Activity At Time of Accident	
Inside Public Use Area?		Water Related Recreation:	
Fee Area?		Non-water Related Recreation:	
Inside Designated Swimming Area?		Other Activities:	
Out granted Area?		Additional Comments	

Body Recovered?	
Alcohol Involvement?	
Drug Involvement?	
PFD Available?	
PFD Worn?	

Summary of Accident	
Was the accident work related?	
Did the accident result in loss of consciousness?	
Does the injury/illness result in or involve HIV infection?	
Does the injury/illness result in or involve Hepatitis?	
Does the injury/illness result in or involve Mental Illness?	
Does the injury/illness result in or involve Needle Stick or cut from sharps that were contaminated with another person's blood or other potentially infectious material?	
Does the injury/illness result in or involve Sexual Assault?	
Does the injury/illness result in or involve Tuberculosis?	
Was the employee medically removed from their duties due to medical surveillance requirements of an OSHA standard?	
Does this person wish to remain anonymous?	

Physician or Other Health Care Information	
Was treatment given by physician or other health care professional?	
Name of Physician or Other Health Care Professional:	

If treatment was given away from the worksite, where was it given?

Facility:		Street:			
City:		State:	Texas	Zip:	

Was employee treated in emergency room?	
Was employee hospitalized overnight as an in-patient?	
If Yes, enter number of days hospitalized:	

Estimated Number of Days			
Calendar Days Away from Work:		On Job Transfer or Restricted Days:	

What was the employee doing just before the Accident occurred

Attention: Do not enter the employee's name or employee's position in this field.

Description:	

What Happened	
Attention: Do not enter the employee's name or employee's position in this field.	
Description:	

Weather (If relevant, describe the weather at the time of the accident)	
Attention: Do not enter the employee's name or employee's position in this field.	
Description:	

Property Involved			
Name of Responsible Person:		**Phone:**	
Owned By:		**Aircraft Destroyed, Missing, or Abandoned:**	

Property Description			
Type of Item	**Make**	**Model**	**Serial/Tag Number**

Address:		**City:**		**Country:**	United States
		State:	Texas	**Zip Code:**	
Estimated Damage ($):					
Damage Description:					

Field Descriptions
Person Type: Contractor; Foreign national; Volunteer; Public Recreating; Govt (civilian); Govt Military; Other
Injury/Illness: Injury; Other illness; Poisoning; Respiratory condition; Skin disorder
Severity Injury/Illness: Fatality; Lost workday case involving days away from work; Non-recordable case; Permanent partial disability; Permanent total disability; Recordable case without lost workdays
Injury/Illness type: Struck by/against; Fall/slip/trip; Caught on/in/between; Punctured/lacerated; Stung/bit by; Contact with/by; Exerted; Exposed; Inhaled; Ingested; Absorbed; Traveling in
Nature of Injury: Amputation; Abrasion; Back strain; Burn; Contusion/bruise; Concussion; Dislocation of joint; Drowning; Fracture; Hearing loss; Hernia; Laceration/cut; Puncture; Strain; Stroke; Traumatic food poisoning; Traumatic heart condition; Traumatic mental disorder; Traumatic respiratory (e.g. carbon monoxide); Traumatic skin disease; Tuberculosis; Traumatic virological/infective; Parasitic disease; Traumatic injury other (list)
Source of Injury: Environmental condition; Building or other area; Walking surface; Electricity, Temperature extreme, Weather, Fire; Water; Mechanical equipment; Guard/shield; Video display terminal; Heating; Motor vehicle/cycle; Boat; bicycle/other non-motorized vehicle; Noise; Radiation; Light; Ventilation; Smoke; Stress; Confined space; Carbon monoxide; Inanimate object; Animal/insect; Human (violence); Diving equipment; Parachute

1. Complete each block of the form.
2. Copy the "Summary of Accident" into the body of the e-mail when you submit it.
3. Ensure that you CC your Supervisor when you submit it.

Submit by E-mail