

<i>(For Safety Staff only)</i>	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	
GOVERNMENT <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		XXXXXXXXXX		XXXX	
2. PERSONAL DATA							
a. Name <i>(Last, First, MI)</i>		b. AGE	c. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		d. SOCIAL SECURITY NUMBER		
e. GRADE		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			
h. EMPLOYMENT STATUS AT TIME OF ACCIDENT <input type="checkbox"/> ARMY ACTIVE <input type="checkbox"/> ARMY RESERVE <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> PERMANENT <input type="checkbox"/> FOREIGN NATIONAL <input type="checkbox"/> SEASONAL <input type="checkbox"/> TEMPORARY <input type="checkbox"/> STUDENT <input type="checkbox"/> OTHER <i>(Specify)</i> _____							
3. GENERAL INFORMATION							
a. DATE OF ACCIDENT <i>(month/day/year)</i>	b. TIME OF ACCIDENT <i>(Military time)</i> hrs	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 <i>(Specify)</i> _____		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 <i>(Specify)</i> _____		g. HAZARDOUS/TOXIC WASTE ACTIVITY <input type="checkbox"/> SUPERFUND <input type="checkbox"/> DERP <input type="checkbox"/> IRP <input type="checkbox"/> OTHER <i>(Specify)</i> _____			
(1) PRIME:							
(2) SUBCONTRACTOR:							
4. CONSTRUCTION ACTIVITIES ONLY <i>(Fill in line and corresponding code number in box from list - see help menu)</i>							
a. CONSTRUCTION ACTIVITY # <input type="text"/>				b. TYPE OF CONSTRUCTION EQUIPMENT # <input type="text"/>			
5. INJURY/ILLNESS INFORMATION <i>(Include name on line and corresponding code number in box for items e, f & g - see help menu)</i>							
a. SEVERITY OF ILLNESS/INJURY # <input type="text"/>			b. ESTIMATED DAYS LOST # <input type="text"/>	c. ESTIMATED DAYS HOSPITALIZED # <input type="text"/>	d. ESTIMATED DAYS RESTRICTED DUTY # <input type="text"/>		
e. BODY PART AFFECTED PRIMARY # <input type="text"/> SECONDARY # <input type="text"/>			g. TYPE AND SOURCE OF INJURY/ILLNESS TYPE # <input type="text"/> SOURCE # <input type="text"/>				
f. NATURE OF ILLNESS/INJURY # <input type="text"/>							
6. PUBLIC FATALITY <i>(Fill in line and correspondence code number in box - see help menu)</i>							
a. ACTIVITY AT TIME OF ACCIDENT # <input type="text"/>				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 <input type="checkbox"/> PICKUP/VAN <input type="checkbox"/> AUTOMOBILE <input type="checkbox"/> TRUCK <input type="checkbox"/> OTHER <i>(Specify)</i> _____		b. TYPE OF COLLISION <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 <i>(Specify)</i> _____			c. SEAT BELTS		
					USED	NOT USED	
					(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 <i>(Fill in line and correspondence code number in box from list - see help menu)</i>							
a. TYPE OF VESSEL/FLOATING PLANT # <input type="text"/>				b. TYPE OF COLLISION/MISHAP # <input type="text"/>			
10. ACCIDENT DESCRIPTION <i>(Use additional paper, if necessary)</i>							

11. CAUSAL FACTOR(S) (Read Instruction Before Completing)					
a. (Explain YES answers in item 13)	YES	NO	a. (CONTINUED)	YES	NO
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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/resources provided to properly perform the activity/task?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
HUMAN FACTORS: Did any human factors such as, size or strength of person, etc., contribute to 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 (If yes, attach a copy.) <input type="checkbox"/> NO		
ENVIRONMENTAL FACTORS: Did heat, cold, dust, sun, glare, etc., contribute to the accident?	<input type="checkbox"/>	<input type="checkbox"/>			

12. TRAINING		
a. WAS PERSON TRAINED TO PERFORM ACTIVITY/TASK? <input type="checkbox"/> YES <input type="checkbox"/> NO	b. TYPE OF TRAINING. <input type="checkbox"/> CLASSROOM <input type="checkbox"/> ON JOB	c. DATE OF MOST RECENT FORMAL TRAINING. (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	
b. INDIRECT CAUSE(S)	

14. ACTION(S) TAKEN, ANTICIPATED OR RECOMMENDED TO ELIMINATE CAUSE(S).	
DESCRIBE FULLY:	

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 (Mo/Da/Yr)	e. ORGANIZATION IDENTIFIER (Div, Br, Sect)		f. OFFICE SYMBOL
CORPS _____					
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)

13a. DIRECT CAUSE (Continuation)

13b.

INDIRECT CAUSES *(Continuation)*

14.

ACTION(S) TAKEN, ANTICIPATED, OR RECOMMENDED TO ELIMINATE CAUSE(S) *(Continuation)*