

- Initial Report
- Follow-up Report
- Final Report

Contractor Significant Incident Report (CSIR)

Contracting Activity/ROICC Office:		
Accident Classification:		
<input type="checkbox"/> Injury <input type="checkbox"/> Fatality <input type="checkbox"/> Environment <input type="checkbox"/> Procedural Issues <input type="checkbox"/> Lessons Learned <input type="checkbox"/> Illness <input type="checkbox"/> Property Damage <input type="checkbox"/> Other _____		
Involving:		
<input type="checkbox"/> Confined Space <input type="checkbox"/> Equip/Mrt Ver/Mat Handling (Heavy Construction Equip.) <input type="checkbox"/> Hazardous Material <input type="checkbox"/> Crane and Rigging <input type="checkbox"/> Equip/Mrt Ver/Mat Handling (Material Handling) <input type="checkbox"/> Trenching/Excavation <input type="checkbox"/> Diving <input type="checkbox"/> Equip/Mrt Ver/Mat Handling (Man-Lift/Elevated Platform) <input type="checkbox"/> Waterfront/Marine Operations <input type="checkbox"/> Demolition/Renovation <input type="checkbox"/> Fall from Ladder <input type="checkbox"/> Fall from Scaffold <input type="checkbox"/> Other _____ <input type="checkbox"/> Electrical <input type="checkbox"/> Fall from Roof <input type="checkbox"/> Fire		
Name (Last, First, MI):		
		Age:
		Sex:
Job Title/Description:		Employed By:
Supervisor Name (Last, First, MI) & Title:		Was the person trained to perform this activity/task? <input type="checkbox"/> Yes <input type="checkbox"/> No
What type of training was received (OJT, classroom, etc)?		Date of the most recent formal training and topics discussed?
Witness #1: Name (Last, First, MI):		
		Job Title/Description:
Employed By:		Supervisor Name (Last, First, MI):
Witness #2: Name (Last, First, MI):		
		Job Title/Description:
Employed By:		Supervisor Name (Last, First, MI):
Additional Witnesses:		
<i>(List any additional witnesses on a separate sheet and attach.)</i>		
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Type of Contract:		
<input type="checkbox"/> A/E <input type="checkbox"/> BOS <input type="checkbox"/> CLEAN <input type="checkbox"/> Construction <input type="checkbox"/> Design Build <input type="checkbox"/> FSCC <input type="checkbox"/> FSSC <input type="checkbox"/> JOC <input type="checkbox"/> RAC <input type="checkbox"/> Service <input type="checkbox"/> Other _____		
Contract Number & Title:		Industrial Group & Industrial Type:
Prime Contractor Name/Address/Phone & Fax No:		Sub Contractor Name/Address/Phone & FAX No:
Safety Manager (Last, First, MI):		Safety Manager (Last, First, MI):
Insurance Carrier:		Insurance Carrier:
Date of Accident:	Time of Accident:	Exact Location of Accident:
Describe the accident in detail in your words: (Use the back of page if you need additional space)		
Direct Cause(s) of Accident:		

Indirect Cause(s) of Accident:

Action(s) taken to prevent re-occurrence or provide on-going corrective actions:

Corrective Action Beginning Date:

Anticipated Completion Date:

Personal Protective Equipment:

- Available and used Available and not used Not Required
 Not related to Mishap Wrong PPE for job

List PPE Used:

Type of Construction Equipment (Make, Model, Serial #, VIN#) Involved:

Was Hazardous Material Spilled/Released?

Yes No

Please List Hazardous Material(s) Involved:

Who provided first aid or cleanup of mishap site?

Any blood-borne pathogen exposure, other than EMTs?

Yes No

Who?

List OSHA and EM-385-1-1 standards that were violated:

Was site secured and witness statements taken immediately?

Yes No

By Whom?

6. Injury Illness/Fatality Information**Severity of Injury/Illness:**

- | | |
|---|---|
| <input type="checkbox"/> Fatality | <input type="checkbox"/> Lost Workday Case Involving Days Away From Work |
| <input type="checkbox"/> Temporary Disability | <input type="checkbox"/> Recordable Workday Case Involving Restricted Duty |
| <input type="checkbox"/> Permanent Total Disability | <input type="checkbox"/> Other Recordable Case <input type="checkbox"/> Recordable First Aid Case |
| <input type="checkbox"/> Permanent Partial Disability | <input type="checkbox"/> Non-Recordable Case <input type="checkbox"/> No Injury |

Estimated Days Lost:**Estimated Days Hospitalized:****Estimated Days Restricted Duty:****List Primary Body Part Affected:****List Other Body Part(s) Affected:****Nature of Injury/Illness for Primary Body Part (Examples: Amputation, Burn, Hernia):****Type of Accident (Examples: Fall same level, Lifting, Bitten, Exerted):****Source of Accident (Examples: Crane, Carbon Monoxide, Ladder, Welding Equipment):****7. Causal Factors (Explain answers on supplementary sheet)**

- | | |
|---|--|
| • Design – Design of facility, workplace, or equipment was a factor? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Inspection/Maintenance – Inspection & Maintenance procedures were a factor? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Persons Physical Condition – In your opinion, the physical condition of the person was a factor? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Operation Procedures – Operating procedures were a factor? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Job Practices – One or more job safety/health practices not being followed when the accident occurred contributed to the accident? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Human Factors – One or more human factors, such as a person's size or strength contributed to the accident? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Environmental Factors – Heat, cold, dust, sun, glare, etc., contributed to the accident? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Chemical and Physical Agent Factors – Exposure to chemical agents, such as dust, fumes, mist, vapors, or physical agents such as noise, radiation, etc., contributed to the accident? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Office Factors – Office setting such as lifting office furniture, carrying, stooping, contributed to the accident? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Support Factors – Inappropriate tools/resources were provided to perform the task? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • PPE – Improper selection, use or maintenance of PPE contributed to the accident? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Drugs/Alcohol – In your opinion, were drugs or alcohol a factor? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Job Hazard Analysis – The lack of an adequate (IAW-EM-385-1-1 Sec 01.A) activity hazard analysis was a contributing factor. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Job Hazard Analysis – JHA was not site specific and/or did not address the type of work/operations performed when the mishap occurred. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Management – A lack of adequate supervision contributed to the accident. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Management – Inadequate information was provided at pre con meeting. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Date OSHA was Notified:	Date(s) of Investigation:	Date of citation: (Attach Copy)	Dollar amount of Penalties:
Name (Last, First, MI):		Date of Report:	
Title:		Signature:	
Employer:			
Phone #:			

CONTRACTOR SIGNIFICANT INCIDENT REPORT (CSIR) INSTRUCTIONS

Complete Sections Appropriate to Incident (Rev. 06/02).

NOTE: THE ATTACHED CSIR FORM IS TO BE USED BY CONTRACTORS TO RECORD THE RESULTS OF THEIR ACCIDENT/INCIDENTS INVESTIGATIONS AND SHALL BE PROVIDED TO THE CONTRACTING OFFICER WITHIN THE REQUIRED TIMEFRAMES.

GENERAL. Complete a separate report for each person who was injured in the accident. A report needs to be completed for all OSHA recordable accidents, property damage in excess of \$2000.00 (This amount is for record purposes only. GOV is not required to enter property damage reports into FAIR database if it is less than \$10,000.00.), WHE accidents, or near miss/high visibility mishaps. Please type or print legibly. Appropriate items shall be marked with an "X" in box(es), non-applicable sections shall be marked "N/A". If additional space is needed, provide the information on a separate sheet of paper and attach to the completed form.

Mark the report:

INITIAL – If this form is being used as initial notification of a Fatality or High Visibility Mishap. The initial form is due within 4 hours of a serious accident. A form marked 'Follow-up' or 'Final' is required within 5 days.

FOLLOW-UP – If you are providing additional information on a report previously submitted.

FINAL – If you are providing a completed report and expect no changes.

SECTION 1 – GENERAL INFORMATION

CONTRACTING ACTIVITY/ROICC OFFICE - Enter the name and address of the Contracting Office administering the contract under which the mishap took place (e.g. ROICC MCBH, ROICC NORFOLK, PWC GUAM, etc.).

ACCIDENT CLASSIFICATION - INJURY/ILLNESS/FATALITY/PROPERTY DAMAGE-/PROCEDURAL ISSUES/- ENVIRONMENTAL/LESSONS LEARNED/OTHER – Mark the appropriate block(s) if the incident resulted in any of these conditions.

INVOLVING - If the mishap involved any of the conditions listed under "Involving" mark the appropriate box(es). Specific questions associated with each of these conditions are available from the Contracting Officer to assist you in your investigation. When these questions are used they shall be attached as part of this report.

SECTION 2 - PERSONAL INFORMATION

NAME - Enter last name, first name, middle initial of person involved.

AGE - Enter age.

SEX - Enter M for Male and F for Female.

JOB TITLE/DESCRIPTION - Enter the job title/description assigned to the injured person (e.g. carpenter, laborer, surveyor, etc.).

EMPLOYED BY - Enter employment company name of the person involved.

SUPERVISOR'S NAME & TITLE - Enter name and title of the immediate supervisor.

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 healthful manner.

TYPE OF TRAINING - Indicate the specific type of training (classroom or on-the-job) that the injured person received before the accident happened.

DATE OF MOST RECENT FORMAL TRAINING/TOPICS DISCUSSED - 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. List topics that were discussed at the training identified above.

SECTION 3 - WITNESS INFORMATION

The following applies to Witness #1 and Witness #2:

WITNESS NAME - Enter last name, first name, middle initial of the witness.

JOB DESCRIPTION/TITLE - Enter the job title/description assigned to the witness (e.g. carpenter, laborer, surveyor, etc.).

EMPLOYED BY - Enter the name of the employment company of the witness.

SUPERVISORS NAME - Enter name of immediate supervisor of the witness.

ADDITIONAL WITNESSES - Provide same information, as above, for each witnesses. Use additional pages if necessary.

SECTION 4 - CONTRACTOR INFORMATION

TYPE OF CONTRACT - Mark appropriate box. A/E means architect/engineer. If "OTHER" is marked, specify type of contract on line provided.

CONTRACT NUMBER/TITLE - Enter complete contract number and title of prime contract (e.g. N62477-85-C-0100, 184 Pearl City Hsg. Revitalization).

CONSTRUCTION INDUSTRIAL GROUP AND INDUSTRIAL TYPE – This is the type of construction that will be done at this project.

1. First, you must choose the Industrial Group. You have 4 choices to choose from: (**NOTE!** Review of the Industrial Types below and knowing what the projects scope of work is will assist you in deciding what the Industrial Group should be.)

- a. Buildings
 - b. Heavy Industrial
 - c. Infrastructure
 - d. Light Industrial
2. Once you have chosen the Industrial Group, you now select the Industrial Type. You have multiple choices under each Group, chose the one you feel fits the project most closely because on most projects there won't be an exact match:
- a. Buildings:
 - (1) Communications Ctr.
 - (2) Dormitory/Hotel
 - (3) High-rise Office
 - (4) Hospital
 - (5) Housing
 - (6) Laboratory
 - (7) Low-rise Office
 - (8) Maintenance Facility
 - (9) Parking Garage
 - (10) Physical Fitness Ctr.
 - (11) Restaurant/Nightclub
 - (12) School
 - (13) Warehouse
 - b. Heavy Industrial:
 - (1) Chemical Mfg.
 - (2) Electrical (Generating)
 - (3) Environmental
 - (4) Metals Refining/Processing
 - (5) Mining
 - (6) Natural Gas Processing
 - (7) Oil Exploration/Production
 - (8) Oil Refining
 - (9) Pulp and Paper
 - c. Infrastructure:
 - (1) Airport
 - (2) Electrical Distribution
 - (3) Flood Control
 - (4) Highway
 - (5) Marine Facilities
 - (6) Navigation
 - (7) Rail
 - (8) Tunneling
 - (9) Water/Wastewater
 - d. Light Industrial:
 - (1) Automotive Assembly/Mfg.
 - (2) Consumer Products Mfg.
 - (3) Foods
 - (4) Microelectronics Mfg.
 - (5) Office Products Mfg.
 - (6) Pharmaceuticals Mfg.

CONTRACTOR'S NAME/ADDRESS/PHONE NUMBER

- (1) PRIME - Enter the exact name (title of firm), address, phone and fax numbers of the prime contractor.
- (2) SUBCONTRACTOR - Enter the exact name, address, phone and fax numbers of any subcontractor involved in the accident.

SAFETY MANAGER'S NAME

- (1) PRIME - Enter the name of the prime contractor safety manager.
- (2) SUBCONTRACTOR - Enter the name of the subcontractors safety manager.

INSURANCE CARRIER

- (1) PRIME - Enter the exact name/title of the prime's insurance company. Policy number not required.
- (2) SUBCONTRACTOR - Enter the exact name of the subcontractor's insurance company. Policy number not required.

SECTION 5 - ACCIDENT DESCRIPTION

DATE OF ACCIDENT - Enter the month, day, and year of accident.

TIME OF ACCIDENT - Enter the local time of accident in military time. Example: 14:30 hrs (not 2:30 p.m.).

EXACT LOCATION OF ACCIDENT - Enter facts needed to locate the accident scene (installation/project name, building/room number, street, direction and distance from closest landmark, etc.).

DESCRIBE THE ACCIDENT IN DETAIL. Fully describe the accident in the space provided. If property damage involved, give estimated dollar amount of damage and/or repair costs involved. If additional space is needed continue on a separate sheet and attach to this report. Give the sequence of events that describe what happened leading up to and including the accident. Fully identify personnel and equipment involved and their role(s) in the accident. Ensure that relationships between personnel and equipment are clearly specified. Ensure questions below regarding direct cause(s), indirect cause(s), and actions taken are answered. **NOTE!** Review questions in Section 7 below before completing.

DIRECT CAUSE(S) - The direct cause is that single factor which most directly lead to the accident. See examples below.

INDIRECT CAUSE(S) - Indirect cause are those factors, which contributed to, but did not directly initiate the occurrence of the accident.

Examples for Direct and Indirect Cause:

1. Employee was dismantling scaffold and fell 12 feet from unguarded opening.
Direct cause: Failure to provide fall protection at elevation

Indirect causes: Failure to enforce safety requirements: improper training/motivation of employee (possibility that employee was not knowledgeable of fall protection requirements or was lax in his attitude toward safety); failure to ensure 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 contractor vehicle. (note contractor vehicles was in proper safe working condition.)

Direct cause: Failure of contractor driver to maintain control of and stop contractor vehicle within safe distance.

Indirect cause: Failure of employee to pay attention to driving (defensive driving).

ACTION(S) TAKEN TO PREVENT RE-OCCURRENCE OR PROVIDE ON-GOING CORRECTIVE ACTIONS. Fully describe all the actions taken, anticipated, and recommended to eliminate the cause(s) and prevent reoccurrence of similar accidents/illnesses. Continue on back or additional sheets of paper if necessary to fully explain and attach to the complete report form.

CORRECTIVE ACTION DATES -

(1) Beginning - Enter the date when the corrective action(s) identified above will begin.

(2) Anticipated Completion - Enter the date when the corrective action(s) identified above will be completed.

PERSONAL PROTECTIVE EQUIPMENT (PPE) - Mark appropriate box(es) and list PPE which was being used by the injured person at the time of the accident (e.g. protective clothing, shoes, glasses, goggles, respirator, safety belt, harness, etc.)

TYPE OF CONTRACTOR EQUIPMENT - Enter the Serial Number, Model Number and specific type of equipment involved in the mishap (e.g. dump truck (off highway), crane (rubber tire), pump truck (concrete), etc.).

WAS HAZARDOUS MATERIAL SPILLED/RELEASED? - Mark appropriate block and list name(s) of any reportable quantities of hazardous materials spilled/released during the mishap.

WHO PROVIDED FIRST AID OR CLEAN-UP OF MISHAP SITE? - List name(s) of individual(s) and employer, if known.

ANY BLOOD-BORNE PATHOGEN EXPOSURE, OTHER THAN EMT? - Mark appropriate block and list name(s) of individual(s) and employer, if known.

LIST OSHA AND/OR EM 385-1-1 STANDARDS THAT WERE VIOLATED. - Self explanatory.

WAS SITE SECURED AND WITNESS STATEMENT TAKEN IMMEDIATELY? - Mark appropriate block and list by whom.

SECTION 6 - INJURY/ILLNESS/FATALITY INFORMATION

SEVERITY OF INJURY/ILLNESS - Mark appropriate box.

ESTIMATED DAYS LOST - Enter the estimated number of workdays the person will lose from work. Update when final data is known.

ESTIMATED DAYS HOSPITALIZED - Enter the estimated number of workdays the person will be hospitalized. Update when final data is known.

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. Update when final data is known.

BODY PART(S) AFFECTED - Enter the most appropriate primary and when applicable, secondary, etc. body part(s) affected (e.g. arm: wrist: abdomen: single eye: jaw : both elbows: second finger: great toe: collar bone: kidney, etc.).

NATURE OF INJURY/ILLNESS FOR PRIMARY BODY PART - Enter the most appropriate nature of injury/illness (e.g. amputation, back strain, dislocation, laceration, strain, asbestosis, food poisoning, heart conditions, etc.).

TYPE AND SOURCE OF INJURY/ILLNESS - Type and Source Codes are used to describe what caused the incident.

(1) TYPE Code stands for an "Action" (Example: Worker, installing conduit, lost his balance and fell five feet from a ladder. Type Code: Fell different levels".) Select the most appropriate Type of injury from the list below:

TYPE OF INJURY/ILLNESS

STRUCK BY/AGAINST	CONTACTED CONTACTED WITH (INJURED PERSON MOVING) CONTACTED BY (OBJECT WAS MOVING)
FELL, SLIPPED, TRIPPED SAME LEVEL/DIFFERENT LEVEL/NO FALL	EXERTED LIFTED, STRAINED BY (SINGLE ACTION) STRESSED BY (REPEATED ACTION)
CAUGHT ON/IN/BETWEEN	EXPOSED INHALED/INGESTED/ABSORBED/EXPOSED TO
PUNCTURED, LACERATED PUNCTURED BY/CUT BY/STUNG BY/BITTEN BY	TRAVELING IN

(2) SOURCE Code stands for an "object or substance." (Example: Worker, installing conduit, lost his balance and fell five feet from a ladder. Source Code: "Ladder".) Select the most appropriate Source of injury from the list below:

SOURCE OF INJURY/ILLNESS

BUILDING OR WORKING AREA WALKING/WORKING AREA STAIRS/STEPS LADDER FURNITURE BOILER/PRESSURE VESSEL EQUIPMENT LAYOUT WINDOWS/DOORS ELECTRICITY	DUST, VAPOR, ETC. DUST (SILICA, COAT, ETC.) FIBERS ASBESTOS GASES CARBON MONOXIDE MIST, STEAM, VAPOR, FUME WELDING FUMES PARTICLES (UNIDENTIFIED)
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ENVIRONMENT CONDITION TEMPERATURE EXTREME (INDOOR) WEATHER (ICE, RAIN, HEAT, ETC.) FIRE, FLAME, SMOTE (NOT TABACCO) NOISE RADIATION LIGHT VENTILATION TOBACCO SMOKE STRESS (EMOTIONAL) CONFINED SPACE	CHEMICAL, PLASTIC, ETC. DRY CHEMICAL - CORROSIVE DRY CHEMICAL - TOXIC DRY CHEMICAL - EXPLOSIVE DRY CHEMICAL - FLAMMABLE LIQUID CHEMICAL - CORROSIVE LIQUID CHEMICAL - TOXIC LIQUID CHEMICAL - EXPLOSIVE LIQUID CHEMICAL - FLAMMABLE PLASTIC WATER MEDICINE
MACHINE OR TOOL HAND TOOL (POWERED: SAW, GRINDER, ETC.) HAND TOOL (NON POWERED) MECHANICAL POWER TRANSMISSION APPARATUS GUARD, SHIELD (FIXED, MOVEABLE, INTERLOCK) VIDEO DISPLAY TERMINAL PUMP, COMPRESSOR, AIR PRESSURE TOOL HEATING EQUIPMENT WELDING EQUIPMENT	INANIMATE OBJECT BOX, BARREL, ETC. PAPER METAL ITEM, MINERAL NEEDLE GLASS SCRAP, TRASH, WOOD FOOD CLOTHING, APPAREL, SHOES
MACHINE OR TOOL HAND TOOL (POWERED: SAW, GRINDER, ETC.) HAND TOOL (NON POWERED) MECHANICAL POWER TRANSMISSION APPARATUS GUARD, SHIELD (FIXED, MOVEABLE, INTERLOCK) VIDEO DISPLAY TERMINAL PUMP, COMPRESSOR, AIR PRESSURE TOOL HEATING EQUIPMENT WELDING EQUIPMENT	INANIMATE OBJECT BOX, BARREL, ETC. PAPER METAL ITEM, MINERAL NEEDLE GLASS SCRAP, TRASH, WOOD FOOD CLOTHING, APPAREL, SHOES
VEHICLE AS DRIVER OF PRIVATELY OWNED, RENTAL VEH. AS PASSENGER OF PRIVATELY OWNED, RENTAL VEH. DRIVER OF GOVERNMENT VEHICLE PASSENGER OF GOVERNMENT VEHICLE COMMON CARRIER (AIRLINE, BUS, ETC.) AIRCRAFT (NOT COMMERCIAL) BOAT, SHIP, BARGE	ANIMATE OBJECT DOG OTHER ANIMAL PLANT INSECT HUMAN (VIOLENCE) HUMAN (COMMUNICABLE DISEASE) BACTERIA, VIRUS (NOT HUMAN CONTACT)
MATERIAL HANDLING EQUIPMENT EARTHMOVER (TRACTOR, BACKHOE, ETC.) CONVEYOR (FOR MATERIAL AND EQUIPMENT) ELEVATOR, ESCALATOR, PERSONNEL HOIST HOIST, SLING CHAIN, JACK CRANE FORKLIFT HANDTRUCK, DOLLY	PERSONAL PROTECTIVE EQUIPMENT PROTECTIVE CLOTHING, SHOES, GLASSES, GOGGLES RESPIRATOR, MASK DIVING EQUIPMENT SAFETY BELT, HARNESS PARACHUTE

SECTION 7 - CAUSAL FACTORS

Review thoroughly. Answer each question by marking the appropriate block. **NOTE!** If any answer is yes, explain in section 5 above.

- (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 inadequately or improperly maintained equipment, tools, workplace, 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) **PERSONS 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 overexertion a factor?
- (4) **OPERATION PROCEDURES** - Did 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 provision 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 tend toward 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 strengths, 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, cold, heat, sun temperature changes, wind, tides, floods, currents, terrain; dust, mud, glare, pressure changes, lighting, 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, fibers, (asbestos, etc.), silica, gases (carbon, monoxide, chlorine, etc.), mists, steam, vapors, fumes, smoke, other particulates, liquid or dry chemicals that are corrosive, toxic, explosive 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/incident?
- (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 lifting 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 utilized 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-toed 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".
- (13) **JOB/ACTIVITY HAZARD ANALYSIS** - Was a written Job/Activity Analysis completed for the task being performed at the time of the accident? If one was made, did it address the hazard adequately or does it need to be updated? If none made, will one be made? These may also need to be addressed in the Corrective Actions Taken section. Mark the appropriate box. If one was made, attach a copy of the analysis to the report.
- (14) **MANAGEMENT** - Did the lack of supervisor or management support play a part in the mishap? Mark the appropriate box.

SECTION - 8 OSHA INFORMATION - Complete this section if applicable

SECTION 9 - REPORT PREPARER

Providing a completed CSIR to the Contracting Officer is the **PRIME CONTRACTOR'S RESPONSIBILITY**. Enter the name, date of report, title, employer, phone number and signature of person completing the accident report and provide it to the Contracting Officer, or his representative, responsible for oversight of that contractor activity. **NOTE!** If prepared by other than the Prime Contractor, a person employed by the Prime Contractor must sign that they have reviewed and concur with the report and it's findings (e.g. company owner, project supervisor/foreman, Safety Officer, etc.).