



## **SUPERVISOR'S INVESTIGATION OF EMPLOYEE'S ACCIDENT/INCIDENT**

The Supervisor's Investigation of Employee's Accident/Incident (AGS-10-91/TWCC-121) is intended to provide the information necessary to evaluate existing and potential risks to State workers. The Employee's Safety and Health Program of the office of the Attorney General, in conjunction with the Risk Management Division of the Texas Workers' Compensation Commission (TWCC), will use this information to initiate and evaluate safety programs. The Supervisor's Investigation of Employee's Accident/Incident Report must be completed by State agencies as part of the safety program and risk management reporting requirements.

### **INSTRUCTIONS FOR COMPLETING AGS-10-91/TWCC-121**

The Supervisor's Investigation of Employee's Accident/Incident Report must be completed each time a reportable injury or occupational illness occurs. Reporting on this form fulfills the requirements of Section 7.21 of the Texas Workers' Compensation Act. This means that a report must be prepared and submitted to the Risk Management Division of the Workers' Compensation Commission when an employee loses time from work in the shift following the injury, or when there is medical cost resulting from the job-related injury. All items are to be completed by the injured employee's immediate supervisor and reviewed by the agency's safety officer for accuracy. The investigation should be completed as soon as possible and submitted to TWCC within 10 days, with corrective action taken at each supervisory level to prevent recurrence of similar incidents. Incidents that do not result in lost time or medical cost should be retained as an aid to the agency's safety program development.

This form may be supplemented by any agency as a part of their safety program. However, supplements should not be forwarded to the TWCC. A copy of all reports must be maintained in the agency for a minimum of three years.

#### **HEADING**

In line one of the heading, print the injured employee's last name, first name and middle initial; social security number; and date of birth.

In line two, indicate the injured employee's sex; the date the employee began working in the assigned unit; the agency's three digit comptroller's code; and the unit's five digit budget number.

In line three, indicate the employee's four digit classification code; date of incident; and time of the incident's occurrence.

#### **SECTION**

- A. Complete the information concerning the extent of the injury. An injury not requiring an E-1 (item 02) is an injury which resulted in no medical cost to State workers' compensation and did not result in the employee losing time from work in the following shift. Medical (item 03) should be checked when there is a medical claim to State workers' compensation but less than one day of lost work. Lost time only (item 04) should be checked when more than one day of work is lost but there is no medical claim to State workers' compensation. Medical and lost time (item 05) is appropriate when there is both a medical claim to State workers' compensation and more than one day is lost from work. Check fatality (item 06) when the injury results in the employee's death.

- B. Check the category which best describes the incident responsible for initiating this report.
- C. Indicate the location of the incident's occurrence. If the incident occurred indoors also fill in the building's name or number. When none of the pre-assigned categories are appropriate, check "other" and fill in the location in the blank provided.
- D. Denote the injured employee's activity at the time of the incident. When none of the listed categories are appropriate, mark "other" and write the activity in the space provided.
- E. Check the body part most affected by the incident. Check "other" and specify the part when none of the categories are appropriate.
- F. Denote the primary type of injury brought about by the incident. Use the "other" category when none of the listed categories apply.
- G. Indicate the type of incident which resulted in filing this report. Check "other" when none of the pre-assigned categories are appropriate.
- H. Indicate the physical object most directly related to the incident. When none of the listed categories are appropriate, check "other" and specify the type of object.
- I. Denote the act or practice resulting in the incident. Check "other" and specify when none of the pre-assigned categories are appropriate.
- J. Check the most appropriate, or primary, physical hazards associated with the incident. When appropriate check "other" and specify.
- K. Indicate whether the State or the unit had a safety rule which could have prevented this incident.
- L. Indicate whether the rule(s) denoted in item K. were violated.
- M. Check all actions already taken or planned to prevent a recurrence of this incident. Check "other" and specify when appropriate.
- N. Give a brief narrative description of the incident. Include who was involved, what happened, where the incident occurred, when it happened, why the incident occurred and how it happened.
- P.1. Submit the AGS-10-91/TWCC-121 to the unit's additional duty safety officer for review and comment. A signature is needed whether or not a comment was included.
- P.2. Once this form has been completed by the injured employee's supervisor, and reviewed by the additional duty safety officer, it should be submitted to the additional duty safety officer's supervisor for review, comments if appropriate, and signature.
- P.3. Submit completed form to the agency's facility safety manager for review of correctness and completeness. When the form is correct and positive action has been initiated to prevent recurrence of similar accidents/incidents, the safety manager should make appropriate comments, sign and date the form. When the report was prepared as a result of medical cost to State workers' compensation or as a result of time lost from work in the following shift (items 03 through 06 in section A.), this form must be returned to the Risk Management Division of the TWCC within ten (10) days through interagency mail or at the following address:

TEXAS WORKERS' COMPENSATION COMMISSION  
Risk Management Division  
Southfield Building  
4000 South I.H. 35  
Austin, Texas 78704-1287

# SUPERVISOR'S INVESTIGATION OF EMPLOYEE'S ACCIDENT/INCIDENT

1. LAST NAME OF INJURED	2. FIRST NAME	3. M.I.	4. SOCIAL SECURITY NUMBER	5. DATE OF BIRTH / /
6. SEX M <input type="checkbox"/> F <input type="checkbox"/>	7. DATE OF EMPLOYMENT IN UNIT / /	8. AGENCY NUMBER (COMPTROLLER'S CODE)		9. BUDGET NUMBER OF ASSIGNED UNIT
10. JOB CLASSIFICATION CODE	11. POSITION STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Floater (fills where needed)		12. DATE OF INCIDENT / /	13. TIME OF INCIDENT a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>

**A. EXTENT OF INJURY (Check one only)**

01 No injury (incident only)  
 02 Injury not requiring a TWCC-1  
 03 Medical  
 04 Lost time only (more than one day)  
 05 Medical and lost time  
 06 Fatality

**B. CATEGORY (Check one only)**

01 Occupational injury (accident)  
 02 Occupational injury (aggressive behavior)  
 03 Occupational illness/disease

**C. SPECIFIC LOCATION OF OCCURRENCE (Check one only)**

**INDOORS:**  
 BUILDING INVENTORY NO. \_\_\_\_\_

01 Auditorium  
 02 Bath/Toilet area  
 03 Boiler room  
 04 Canteen,Snack bar  
 05 Cell block  
 06 Classroom  
 07 Closet  
 08 Day room  
 09 Dormitory/Living room  
 10 Elevator  
 11 Food service area/Dining/Kitchen  
 12 Garage  
 13 Gymnasium/Recreation  
 14 Hallway/Corridor  
 15 Hospital/Clinic/Dispensary  
 16 Laboratory  
 17 Laundry  
 18 Library  
 19 Nursing station  
 20 Office areas  
 21 Program areas  
 22 Ramp  
 23 Sales store/Outlet  
 24 Seclusion room  
 25 Sleeping room  
 26 Steps/Stairs/Stairway  
 27 Storage area  
 28 Waiting room  
 29 Workshop/Technical trades  
 30 Other (specify) \_\_\_\_\_

**OUTDOORS:**

31 Athletic field  
 32 Campus  
 33 Grounds  
 34 Highway/Road/Street  
 35 Loading dock  
 36 Park or recreation area  
 37 Parking lot  
 38 Roof  
 39 Sidewalk  
 40 Steps/Stairs/Stairway  
 41 Storage area  
 42 Swimming pool area  
 43 Tower  
 44 Other (specify) \_\_\_\_\_

**D. ACTIVITY ENGAGED IN BY INJURED AT TIME OF INJURY (Check one only)**

<input type="checkbox"/> 01 Bathing	<input type="checkbox"/> 21 Moving
<input type="checkbox"/> 02 Buffing	<input type="checkbox"/> 22 Operating
<input type="checkbox"/> 03 Carrying	<input type="checkbox"/> 23 Pulling
<input type="checkbox"/> 04 Cleaning	<input type="checkbox"/> 24 Pushing
<input type="checkbox"/> 05 Climbing	<input type="checkbox"/> 25 Reaching
<input type="checkbox"/> 06 Cutting	<input type="checkbox"/> 26 Redirecting
<input type="checkbox"/> 07 Descending	<input type="checkbox"/> 27 Restraining
<input type="checkbox"/> 08 Digging	<input type="checkbox"/> 28 Running
<input type="checkbox"/> 09 Dressing	<input type="checkbox"/> 29 Sanding
<input type="checkbox"/> 10 Driving	<input type="checkbox"/> 30 Sawing
<input type="checkbox"/> 11 Eating	<input type="checkbox"/> 31 Searching
<input type="checkbox"/> 12 Escorting	<input type="checkbox"/> 32 Securing
<input type="checkbox"/> 13 Exercising	<input type="checkbox"/> 33 Sitting
<input type="checkbox"/> 14 Feeding	<input type="checkbox"/> 34 Standing
<input type="checkbox"/> 15 Grinding	<input type="checkbox"/> 35 Stripping
<input type="checkbox"/> 16 Grooming	<input type="checkbox"/> 36 Turning
<input type="checkbox"/> 17 Jumping	<input type="checkbox"/> 37 Walking
<input type="checkbox"/> 18 Lifting	<input type="checkbox"/> 38 Welding
<input type="checkbox"/> 19 Loading	<input type="checkbox"/> 39 Other (specify) _____
<input type="checkbox"/> 20 Mopping	

**E. BODY PART INJURED (Most serious)**

<input type="checkbox"/> 01 Ankle	<input type="checkbox"/> 16 Internal organ
<input type="checkbox"/> 02 Arm	<input type="checkbox"/> 17 Jaw
<input type="checkbox"/> 03 Back	<input type="checkbox"/> 18 Knee(s)
<input type="checkbox"/> 04 Buttocks	<input type="checkbox"/> 19 Leg(s)
<input type="checkbox"/> 05 Cheek	<input type="checkbox"/> 20 Mouth
<input type="checkbox"/> 06 Chest	<input type="checkbox"/> 21 Neck
<input type="checkbox"/> 07 Chin	<input type="checkbox"/> 22 Nose
<input type="checkbox"/> 08 Ear(s)	<input type="checkbox"/> 23 Pelvis
<input type="checkbox"/> 09 Eye(s)	<input type="checkbox"/> 24 Rib(s)
<input type="checkbox"/> 10 Foot-Feet	<input type="checkbox"/> 25 Scalp
<input type="checkbox"/> 11 Finger/Thumb(s)	<input type="checkbox"/> 26 Shoulder
<input type="checkbox"/> 12 Forehead	<input type="checkbox"/> 27 Toe(s)
<input type="checkbox"/> 13 Groin	<input type="checkbox"/> 28 Wrist(s)
<input type="checkbox"/> 14 Hand	<input type="checkbox"/> 29 Other (specify) _____
<input type="checkbox"/> 15 Hips	

**F. TYPE OF INJURY (Check primary one)**

<input type="checkbox"/> 01 Abrasion	<input type="checkbox"/> 15 Heat exhaustion
<input type="checkbox"/> 02 Amputation	<input type="checkbox"/> 16 Hernia
<input type="checkbox"/> 03 Bite	<input type="checkbox"/> 17 Infection
<input type="checkbox"/> 04 Bruise	<input type="checkbox"/> 18 Inflammation
<input type="checkbox"/> 05 Burn	<input type="checkbox"/> 19 Internal injuries
<input type="checkbox"/> 06 Concussion	<input type="checkbox"/> 20 Puncture
<input type="checkbox"/> 07 Cut	<input type="checkbox"/> 21 Rupture
<input type="checkbox"/> 08 Dermatitis	<input type="checkbox"/> 22 Scratch
<input type="checkbox"/> 09 Dislocation	<input type="checkbox"/> 23 Shock
<input type="checkbox"/> 10 Foreign object	<input type="checkbox"/> 24 Sprain
<input type="checkbox"/> 11 Fracture	<input type="checkbox"/> 25 Sting
<input type="checkbox"/> 12 Frostbite	<input type="checkbox"/> 26 Strain
<input type="checkbox"/> 13 Hearing loss	<input type="checkbox"/> 27 Other (specify) _____
<input type="checkbox"/> 14 Heart attack	

**G. TYPE OF OCCURRENCE (Check one only)**

01 Aggression (client, student, inmate, patient)  
 02 Bodily reaction (drug, medication)  
 03 Caught in, on, under, or between  
 04 Contact with chemicals  
 05 Contact with electric current  
 06 Contact with temperature extremes

**G. CONTINUED**

07 Fall on same level  
 08 Fall on different level  
 09 Over-exertion (exceeding physical ability resulting in strain, rupture)  
 10 Overexposure to environmental hazards (noise, toxic)  
 11 Slip (not a fall)  
 12 Struck against (rough, sharp object)  
 13 Struck by falling, moving object  
 14 Other (specify) \_\_\_\_\_

**H. PHYSICAL THING MOST CLOSELY ASSOCIATED WITH OCCURRENCE (Check one)**

01 Aircraft  
 02 Air pressure  
 03 Animal (snake, dog, horse, etc.)  
 04 Athletic equipment (baseball, bat, dart, etc.)  
 05 Attachments (belt, pulley, gear, shaft)  
 06 Building component  
 07 Cabinet  
 08 Chemical (solid, liquid, or gas)  
 09 Clothing  
 10 Container (bottle, box, barrel, cylinder, etc.)  
 11 Curb  
 12 Doors (automatic, manual, revolving)  
 13 Drugs or medicine  
 14 Dust  
 15 Electrical apparatus  
 16 Elevator, escalator  
 17 Explosives  
 18 Eyewear  
 19 Fan  
 20 Fire, flame, smoke  
 21 Floor  
 22 Food products  
 23 Fumes  
 24 Furniture, fixtures  
 25 Gas  
 26 Glass items  
 27 Gun  
 28 Ground (earth)  
 29 Hand tool  
 30 Heating equipment  
 31 Hoisting equipment  
 32 Icy condition  
 33 Infectious or parasitic agent  
 34 Inmate, client, employee  
 35 Insect  
 36 Kitchen equipment  
 37 Knife  
 38 Lighting fixture and equipment  
 39 Ladder, scaffold  
 40 Locker  
 41 Machine  
 42 Material handling equipment  
 43 Metal  
 44 Mineral items (asphalt, clay, gravel, etc.)  
 45 Motor vehicle  
 46 Needle  
 47 Office equipment (chair, desk, cabinet, etc.)  
 48 Paint  
 49 Particle  
 50 Pavement  
 51 Person (other than client, inmate, employee)  
 52 Pipe  
 53 Platform, dock, ramp

Continued On Other Side

**H. CONTINUED**

54 Pole

55 Power tool or machinery (lathe, saw, etc.)

56 Radiating equipment (microwave, x-ray, etc.)

57 Receptacle

58 Smoke

59 Stair, step

60 Sun

61 Trench/Ditch

62 Vegetation

63 Weather

64 Wood

65 Other (specify) \_\_\_\_\_

**I. CONTINUED**

21 Riding moving equipment not designed for passengers

22 Unobservant (daydreaming, inattentive, etc.)

23 Using unsafe/defective tool, material, equipment

24 Using wrong tool, material equipment

25 Working/Walking under suspended load (crane, hoist, derrick)

26 Working in a confined space without proper safeguard

27 Working without adequate lighting

28 Other (specify) \_\_\_\_\_

**J. CONTINUED**

21 Unsafe/Defective hand or electric tools

22 Unsafe equipment

23 Unsafe material

24 Unsafe vehicle

25 Unshored trench, excavation, etc.

26 Walkway, sidewalk, pavement

27 Other (specify) \_\_\_\_\_

**I. ACT/PRACTICE ASSOCIATED WITH OCCURRENCE (Check one only)**

01 Contact with electrical source (tool, device, wire, etc.)

02 Entering an unauthorized area

03 Failure to practice safe driving technique

04 Failure to use established route or taking short cut

05 Failure to use handrail, grab bar

06 Failure to use lockout device

07 Failure to use/wear personal protective equipment (PPE)

08 Failure to warn of known hazards (i.e. no safety sign, light, barricade, instruction, etc.)

09 Failure to wear appropriate dress (shoes, shirt, blouse)

10 Handling (of object, material, item, thing)

11 Horseplay

12 Improper making or storing (non-compatible material, chemicals, etc.)

13 Improper placing or storing (materials, tools, equipment)

14 Lifting (including position, stance)

15 Making safety devices inoperative

16 No unsafe act/practice on the part of employee

17 Operating/Working at unsafe speed

18 Operating without proper authority/clearance

19 Over or unnecessary exposure to hazards (gas, fumes, dust, chemicals, mist, radiation, etc.)

20 Repairing or servicing moving object/thing (machine, equipment, etc.)

**J. CONDITION (PHYSICAL HAZARD) ASSOCIATED WITH OCCURRENCE (Check one)**

01 Congested area

02 Electrical hazard (uninsulated wire, overloaded circuit, inadequate ground, etc.)

03 Excessive noise

04 Harmful animals/insects/reptiles

05 Health hazards (radiation, gas, fumes, dust, vapors, etc.)

06 Improper housekeeping

07 Improperly stored chemicals, hazardous substances

08 Inadequate ventilation

09 Inadequate or no warning signs

10 Layout or design (office, shop, equipment)

11 Lighting

12 Mislabeled/Unlabeled chemicals, hazardous materials, etc.

13 No unsafe condition

14 Open trench, hole, ditch, sharp drop-off

15 Poisonous vegetation (oak, ivy, etc.)

16 Protruding object (nail, wire, splinter, etc.)

17 Rough/Sharp objects

18 Slipping or tripping hazard

19 Step, stairs, ladder, or other working surfaces

20 Unguarded machine, belt, pulley, roller, etc.

**K. DID THE STATE OR THE UNIT HAVE A SAFETY RULE, REGULATION, OR STANDARD THAT WOULD HAVE PREVENTED THE OCCURRENCE?**

01 Yes  02 No

**L. WAS THE RULE, REGULATION, OR STANDARD VIOLATED?**

01 Yes  02 No

**M. ACTION(S) TAKEN OR PLANNED TO PREVENT RECURRENCE (Check all that apply)**

01 Action taken with employee for violating rules, regulations or procedures

02 All employees were made aware of the occurrence cause, consequence, and action taken to prevent recurrence

03 Employee given basic training

04 Employee given refresher or remedial training

05 Existing rule, regulation or standard (SOP) enforced

06 Existing rule, regulation or standard (SOP) revised

07 New rule, regulation or standard prepared

08 Physical hazard(s) corrected

09 Other positive action taken \_\_\_\_\_

**N. DESCRIBE BRIEFLY IN NARRATIVE FORM THE CIRCUMSTANCES THAT LED TO AND CAUSED THIS OCCURRENCE.**

ANSWER: WHO? WHAT? WHERE? WHEN? WHY? AND HOW? ( Use additional sheet if necessary)

INJURED'S IMMEDIATE SUPERVISOR (print)	SIGNATURE	DATE	PHONE
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<b>P. REVIEWED BY</b>	P.1 SECTION/DEPARTMENT/DIVISION ADDITIONAL DUTY SAFETY OFFICER. COMMENT:	
	SIGNATURE	DATE
	P.2 SECTION/DEPARTMENT/DIVISION HEAD. COMMENT:	
	SIGNATURE	DATE
	P.3 AGENCY OR FACILITY SAFETY MANAGER.	
A) Repeat occurrence: <input type="checkbox"/> 01 No <input type="checkbox"/> 02 Yes; total incidents: <input type="checkbox"/> 03 Two <input type="checkbox"/> 04 Three <input type="checkbox"/> 05 Four <input type="checkbox"/> 06 Five <input type="checkbox"/> 07 Over Five		
B) Were more than two (2) workers injured in this accident? (if so, complete a separate form for each employee) <input type="checkbox"/> 01 Yes <input type="checkbox"/> 02 No		
C) Comment:		
SIGNATURE	DATE	