**DOE F 5484.3** (05-98) All Other Editions

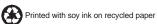
Are Obsolete

## U.S. Department of Energy INDIVIDUAL ACCIDENT/INCIDENT REPORT

OMB Control No. 1910-0300

Official Use Only - Privacy Act

General Information				
1. Organization Name:	5. Investigation Type:			
Organization Code:	6. Department, Division, or I.D. Code:			
2. Case Number: ☐ Yes	7. Date of Occurrence: Month Day Year (YYYY)			
3. Did accident involve more than one reporting organization?  ☐ Yes ☐ No	8. Time of Event: (Military)			
Multiple Case Number:	9. Accident Occurred:			
4. Accident Type: ☐ Injury/Illness ☐ Vehicle	10. On Employer's Premise: ☐ Yes ☐ No			
☐ Property Damage ☐ Other	11. Specific Location:			
Employee Information				
12. Check One:	17. Occupation:			
<ul><li>☐ Operator of Equipment/Vehicle</li><li>☐ Not Applicable</li></ul>	18. Time Employee Began Work: (Military)			
13. Name:	19. Date of Hire: Day Year (YYYY)			
Home Address:	20. Experience on this Job/Equipment:  Under 3 Months			
Address.	20. Experience on this Job/Equipment: ☐ Under 3 Months ☐ 3 to 12 Months			
14. Social Security No.	☐ Over 12 Months			
15. Date of Birth:				
16. Sex:  Female  Male				
(If Property Damage or Vehic	<u> </u>			
Injury/Illness (OSHA Information)				
21. ☐ Injury Code (10)  Illness Codes ☐ Code 7a(21) - Skin disease or disorders	<ul><li>24. Has employee returned to work with no further anticipated workdays lost or restricted?</li><li>☐ Yes</li><li>☐ No</li></ul>			
<ul> <li>Code 7b(22) - Dust diseases of lungs</li> <li>Code 7c(23) - Resp. due to toxic agents</li> <li>Code 7d(24) - Poisoning</li> <li>Code 7e(25) - Disorders-Physical agents</li> <li>Code 7f(26) - Disorders-Repeated trauma</li> <li>Code 7g(29) - All others</li> </ul>	25. Permanent transfer to different job because of accident?  ☐ Yes ☐ No  Terminated because of accident? ☐ Yes ☐ No			
22. Workdays Lost:  (Actual if available or estimated expected)	26. Did employee die? ☐ Yes ☐ No			
23. Workdays Restricted: Label Label (Actual if available or estimated expected)	If "Yes," enter date			



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## **Property/Vehicle Damage**

27.	Property Loss Type (Select One)  Fire/Smoke:				
(If	Property Damage Accident go to Line 30)				
	28. Vehicle Type (Select One)				
	Light Highway: ☐ Automobile ☐ Van ☐ Pickup truck ☐ Motorcycle, moped ☐ Highway vehicle, n.e.c.				
	Heavy Highway: ☐ Bus ☐ Delivery truck ☐ Dump truck ☐ Semitrailer, tractor trailer, trailer truck ☐ Truck, n.e.c. (e.g., fire truck)				
	Air Rotary Wing: ☐ Helicopter ☐ Aircraftrotary wing, n.e.c.				
	Air Fixed Wing: ☐ Jet ☐ Propellerdriven aircraft ☐ Aircraft fixed wing, n.e.c.				
	Other Vehicles:   Railroad   Marine				
29.	9. Was vehicle equipped with seat belts?				
30.	0. Did vehicle accident involve recordable injury? ☐ Yes ☐ No				
31.	31. Total Accident Damage \$L				
	DOE Property/Vehicle \$L				
	Non- DOE Property/Vehicle \$L_L_L_L_L_L_L_L_L_L_L_L_L_L_L_L_L_L_L_				
32.	Claim Against DOE \$ Paid by DOE \$				
	Reimbursable to DOE \$ Paid to DOE \$ Paid to DOE				
33.	3. Are the dollar amounts final? ☐ Yes ☐ No				
Equipment/Hardware/Vehicle Involved (as applicable)					
34.	#1 Equipment  Generic (or brand) name and model				
	#2 Equipment  Generic (or brand) name and model				
35.	Did equipment design or defect contribute to accident cause or severity? ☐ Yes ☐ No				

## **NARRATIVE GUIDE**

## DO NOT INCLUDE THE NAME (OR OTHER PERSONAL IDENTIFIER) OF THE EMPLOYEE/OPERATOR OR WITNESS IN THIS SECTION. Use third person references, e.g., he slipped on the wet floor and broke his right toe.

36.	<ol> <li>Activity in progress at time of accident. Be specific. For example, if the employee was using, of them and tell what he was doing with them.</li> </ol>	equipment or handling materials or chemicals, name	
37.	<ol> <li>Events Describe the accident sequentially, beginning with initiating events. Tell what happened, injury/damage. Use a separate sheet for additional space.</li> </ol>	how it happened and end with nature and extent of	
	Name any objects or substances (e.g., utility knife, glass beaker containing saline solution) invo	olved and tell how they were involved.	
	Describe the nature of the injury/illness/damage. Name the body part effected if injury or illness	s. (e.g., amputation of right index finger at second joint)	
	Name and address of primary health care provider (e.g., physician, nurse, etc.)		
	If hospitalized overnight, name and address of hospital		
38.	8. Accident Causes a. Conditions		
	b. Actions		
	c. Factors influencing a or b.		
39.	9. <u>Corrective Actions</u> (if risk is acceptable, corrective action may not be necessary. If so, indicate "Not applicable" in section "a." below.)  a. Actions taken		
	b. Actions recommended		
	c. To be completed by		
		Telephone	
	Official Position ☐ Supervisor ☐ Safety Professional ☐ Other		
11.	Supervisor responsible for Corrective Action Date	Telephone	
12.	Accident Investigation Contact     (if different from line 40)	Telephone	