

Supervisor's Accident/Crime Investigation Report

MTA Bus _____ LIB _____

TA _____ OA _____ Division/Depot/Facility _____ Date of Report ____/____/____

Brief # _____ **Bus/Vehicle #** _____ **Day** _____ **Accident Date** ____/____/____ **Time** _____ **Hours** _____

Pass/PR # _____ **Operator/Empl.** _____ **DOA** ____/____/____ **Badge** _____ **RDO** _____

Beginning of Work Day _____ (First piece of work immediately following 8 continuous hours off. Include any XPC, DBL, COA etc. worked, if applicable).

Operator's Work Hours Prior to the Incident _____ **Probie? Yes / No** _____

Student? Yes / No **Instructor's Pass/PR #** _____ **Assigned Route** _____ **Run** _____ **Operating Route** _____
 (if different from picked route)

Destination _____ **Street On** _____

Street At (cross street) _____ **At Intersection? Yes / No** _____ **If not at an intersection, Between ...** _____
 _____ (street) and _____ (street). **Circle: Near, Far, Mid-block, Terminus, Other**

Environment: Clear, Rain, Snow, Sun Glare, Fog, High Winds, Overcast, Hail

Street Conditions: Dry, Wet, Black Ice, Flooded, Leaves, Mud, Oil, Ice, Sand, Other

Pavement Conditions: Smooth, Slippery, Pothole, Construction Plates, Uneven, Grooved, Manhole Cover

Grade: Level, Down Hill, Up Hill, Other **Street Type:** Blacktop, Bridge Grate, Brick Face, Cement, Cobblestone, Other

Lighting: Daylight, Dark, Sunrise, Elect. Lighting, Dusk **Bus Stop Area? Yes / No** **Stop Location:** Far, Near, Mid-block

Stop Condition: Good, Blocked, Broken Curb, No Curb, Broken Sidewalk, Dirt, Mud, Pothole, Unpaved, Snow, Ice

Bus/NYCT Vehicle: (Vehicle #1) License Plate # _____ **Damage:** Extensive, Moderate, Slight, None, N/A

Type (Circle): Bus, Truck, Auto **Make** _____ **# Customers** _____ **# Cust. Injuries** _____ **BO/Driver Inj: Y / N** **# Oth. Emp Inj:** _____

Point of Impact Bus	E	F	G	H	6	7	8	9	Point of Impact Vehicle	6	7	8	9	Point of Impact Vehicle	6	7	8	9	0
	D	ARTIC-ULATED			5	BUS				5	AUTO/TRUCK					5	TRUCK		
	C	B	A		4	3	2			4	3	2			4	3	2		1

Action of NYCT Vehicle: Changing Lanes, Leaving Bus Stop, Standing at Bus Stop / at Light / in Traffic, Turning Right / Left, Reverse, Moving Straight

Delay to Service _____ **Delay to Bus** _____ **Bus Status:** BIS, Yard, Tow, Impounded, Spare

Status Changed by: BO, RBO, BMB, SLD, OSS, MGR, SUPT, POLICE, PTSB **Replacement Pass/PR #** _____

Vehicle #2: Auto, Van, Bus, Bicycle, Motorcycle, Truck **License Plate #** _____ **State** _____ **NYCT Vehicle? #** _____

Damage to Vehicle #2: Extensive, Moderate, Slight, None, N/A **# Occupants** (including driver) _____ **# Injuries** _____

Action of Vehicle #2: Changing Lanes, Moving from Curb, Reverse, Turning Right or Left, Passing Right or Left, U-turn Left or Right, Moving Straight

Vehicle #3: Auto, Van, Bus, Bicycle, Motorcycle, Truck **License Plate #** _____ **State** _____

Damage to Vehicle #3: Extensive, Moderate, Slight, None, N/A **# Occupants** (including driver) _____ **# Injuries** _____

Action of Vehicle #3: Changing Lanes, Moving from Curb, Reverse, Turning Right or Left, Passing Right or Left, U-turn Left or Right, Moving Straight

IF THE VEHICLE FLED THE SCENE, FILL IN ALL ABOVE INFORMATION INCLUDING A VEHICLE DESCRIPTION BELOW

Vehicle Fled Scene (Description): Auto, Van, Bus, Bicycle, Motorcycle, Truck **License Plate #** _____ **State** _____

Vehicle Color _____ **Model/Make/Year** _____ **Veh. Description** _____ (Company Logo or Other)

Distinguishing Characteristics _____

INFORMATION OF THE OTHER VEHICLE (If more than one vehicle was involved, use additional forms)

Name of Driver _____

Address of Driver _____

Driver's License # _____ **State Issued** _____ **Male** _____ **Female** _____ **Exp. Date** _____

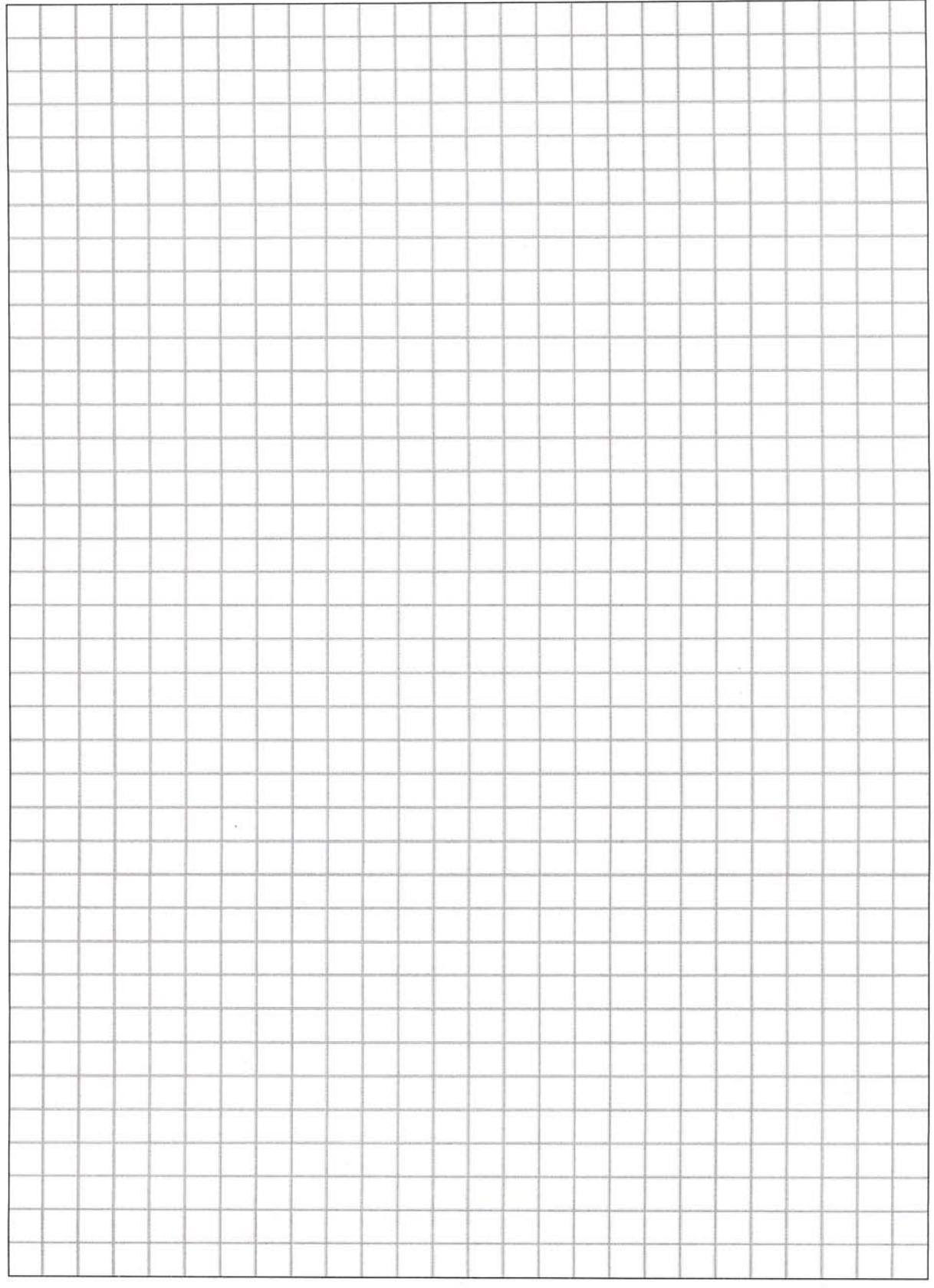
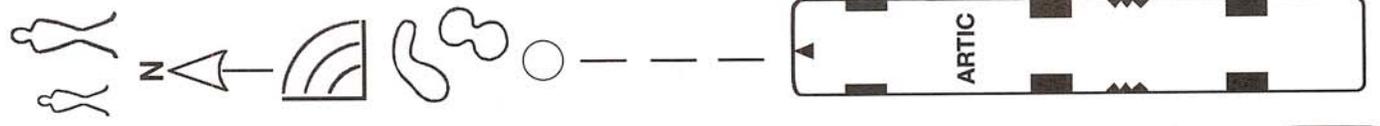
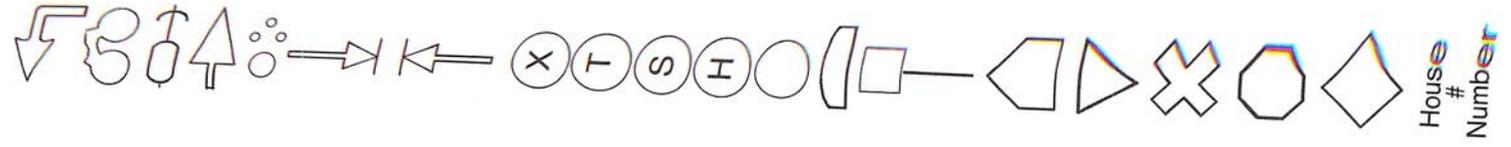
Name of Owner _____ **License Plate #** _____ **State** _____

Address of Owner _____

Vehicle Color _____ **Model** _____ **Make** _____ **Year** _____

Name/Number of Insurance Co. (from FS 20) _____ **Policy #** _____

Date ___/___/___ Time ___ Hours Route ___ Run ___ Operator/ Empl. ___ Pass/PR# ___ Bus/Veh. # ___
 Destination ___ SLD/Manager ___ Pass/PR# ___



Supervisor's Accident/Crime Investigation Report

MTA Bus LIB

TA OA Depot _____ Date of Accident / / Day Time: Hours Vehicle #: _____
 Operator/Empl. _____ Pass/PR #: _____ Route: _____ Run: _____

Bus
 Vehicle
 Pedestrian

INJURED INFORMATION

Name _____ Birth Date / / Sex EMS # _____
 Address _____ City _____ State _____ Zip Code _____
 Hospital _____ Injury to (body part) _____

Name _____ Birth Date / / Sex EMS # _____
 Address _____ City _____ State _____ Zip Code _____
 Hospital _____ Injury to (body part) _____

Name _____ Birth Date / / Sex EMS # _____
 Address _____ City _____ State _____ Zip Code _____
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 Hospital _____ Injury to (body part) _____

COMPLAINANT VICTIM/WITNESS INFORMATION

Name _____ Phone #'s: Home () _____ Work () _____
 Complainant Witness Age Male Female Race _____
 Address _____ City _____ State _____ Zip Code _____

Name _____ Phone #'s: Home () _____ Work () _____
 Complainant Witness Age Male Female Race _____
 Address _____ City _____ State _____ Zip Code _____

Name _____ Phone #'s: Home () _____ Work () _____
 Complainant Witness Age Male Female Race _____
 Address _____ City _____ State _____ Zip Code _____

SLD/Manager (print) _____ Pass/PR #: _____

Title _____ Signature _____



Metropolitan Transportation Authority
NYCT Department of Buses
MTA Bus Company
Long Island Bus

ON-THE-JOB INJURY FORM

Report Date: ___ / ___ / ___

Telephonic Control # _____

NOTICE: Location must call in employee injury within 24 hours of injury (1-888-682-4301) and call the Command Center Accident Desk (1-800-237-2420/1 or 718-927-7869) –TA, or (1-800-237-2330 or 718-927-7868 - OA to phone-in Accident Brief.

Employee & Supervisor: Complete this form upon occurrence of injury or recurrence of injury-on-duty.

Supervisor: Complete the Department Section on front side of form, Employee's Section (if applicable), and the Injury Investigation Form on reverse side. FAX BOTH SIDES OF FORM within 24 hours to the Performance Reporting Unit of the Department of Buses at 718-927-8831; HAND DELIVER WITHIN TWO BUSINESS DAYS the original with brief, and other required documents to Performance Reporting at 25 Jamaica Ave., Room 28A, Brooklyn, NY 11207.

Employee: Complete Employee Section and Differential Application on front side of this report and keep 1 copy.

PLEASE PRINT – FULLY ANSWER ALL QUESTIONS AND BOTH SIDES OF FORM

MTA-NYCT MABSTOA

EMPLOYEE'S SECTION: (If employee is not available, Supervisor must fill out and sign form)

Name: Last _____ First _____ M.I. ____ Pass/Payroll #: _____ Soc. Sec. #: _____
 Home Address (& Apt. #): _____ Home Phone: (____) _____ Date of Birth: ___ / ___ / ___
 City: _____ State: _____ Zip Code: _____ Sex: M F
 Job Title: _____ Title Code: _____ Date of Hire: ___ / ___ / ___
 Date Supervisor Notified: ___ / ___ / ___ Hrs Worked Day of Inj: _____ Hrs Worked Prior 7 Days: _____

Dept./Division: _____ Resp. Ctr. #: _____
 Pre-Injury Work Status: _____ Recurrence of Prior Injury? _____
 Full: Rest: No Work: yes no Unknown Date of Prior Injury: ___ / ___ / ___ RDOs _____
 Hrs. of Duty: _____ Wages/Hr: _____ Work Hrs/Day: _____ Work Hrs/Week: _____ Scheduled Lunch: _____

DESCRIBE INJURY

Injury Date: ___ / ___ / ___ Time: _____ AM PM (circle one)
 Location/Facility/Station/Building: _____ Area/Booth/Vehicle #/Track _____ County _____
 What were you doing when injured or when injury recurred? _____

How did injury/exposure occur? _____

Why did injury occur? _____

Nature of injury: (type of injury AND part of body) _____

Medical Treatment Requested? yes no Received Workers' Comp. Statement of Rights? yes no

Received Injury on Duty Instruction Sheet? yes no

Employee Signature: _____ Date ___ / ___ / ___ Supv. Signature: _____
 (If employee fails to sign)

DIFFERENTIAL APPLICATION

Employee must sign Differential Application to begin processing. Signature does not denote agreement with Supervisor's Report nor Workers' Compensation determinations of eligibility.

I understand that, in making this application for Differential Benefit, I have agreed that the Authority may seek to recoup the value of Differential Benefits paid from any judgement or settlement of an action against third parties I may institute as a result of this Injury.

I hereby apply for payment of differential.

Employee's Name (please print) _____ Employee's Signature: _____ Date: ___ / ___ / ___

DEPARTMENT SECTION:

Was injury observed? yes no
 If yes, was it job related? yes no unknown
 Date Stopped work: ___ / ___ / ___
 Has injured returned to work? yes no
 Return to work date: ___ / ___ / ___

DATE REPORT TO MAC FOR DRUG/ALCOHOL TESTING: ___ / ___ / ___

RULE COMPLIANCE: At time of injury was employee:
 Performing assigned duties? yes no unknown

Supervisor Name (please print) _____ Date ___ / ___ / ___
 Supv. Signature _____ Phone (____) _____

DEPARTMENT OF BUSES ON-THE-JOB INJURY INVESTIGATION FORM

RESPONSE

INJURED EMPLOYEE NAME: _____

PASS NUMBER: _____

Injury Information

FIRST AID RENDERED: yes no Detail: _____ FIRST AT THE INJURY SCENE: _____

AREA SECURED/IMMEDIATE HAZARD ELIMINATED: yes no Why: _____ Time: _____ AM PM

FACT- FINDING

Witness Information

INJURED EMPLOYEE INTERVIEWED: yes no Why: _____ Date: ____/____/____

NAME, PASS NUMBER, JOB TITLE OF ALL WITNESSES: _____

DATE INTERVIEWED: ____/____/____

DATE INTERVIEWED: ____/____/____

INJURY SCENE INFORMATION

LOCATION DETAIL: Bus – passenger/other _____ Bus # _____ Depot: _____ Storeroom # _____ Street _____

Shop _____ Vehicle # _____ Other _____

PHOTOGRAPH TAKEN: yes no Why? _____ SKETCH MADE: yes no Why? _____

DETAIL OF INJURY SCENE:

LIGHTING CONDITIONS: good poor other _____ WEATHER: clear cloudy rain snow other _____

STRUCTURAL ELEMENTS (hole in floor, chipped stair, missing handrail, etc.) good poor Detail: _____

HOUSEKEEPING: good poor Detail: _____ OTHER: _____

EQUIPMENT/MACHINE/TOOL INVOLVED

NAME (include identification number if applicable) _____ CONDITION: good poor OTHER: _____

ANALYSIS

PEOPLE/PROCEDURES

POLICY/PROCEDURE APPLICABLE: yes no FOLLOWED: yes no

TRAINING REQUIRED: yes no COMPLETED: yes no

PERSONAL PROTECTIVE EQUIPMENT REQUIRED: yes no IN USE: yes no

CONDITION OF PPE: good poor Detail _____ OTHER: _____

EQUIPMENT

FAILURE: yes no CAUSE OF FAILURE: IMPROPER OPERATION: _____

LACK OF MAINTENANCE: _____ OTHER: _____

MACHINE/TOOL USED CORRECTLY: yes no INSPECTION REQUIRED: yes no LAST INSPECTION: _____

SAFEGUARDS REQUIRED: yes no IN PLACE: yes no IN USE: yes no

MATERIAL

EXPOSED TO: _____ CONTACT WITH _____ USED CORRECTLY: yes no

SAFEGUARDS REQUIRED: yes no IN PLACE: yes no IN USE: yes no

ENVIRONMENT

HEAT RELATED: yes no COLD RELATED: yes no OTHER: yes no _____

SAFEGUARDS REQUIRED: yes no IN PLACE: yes no IN USE: yes no

MISCELLANEOUS CONTRIBUTING FACTORS

OTHER EMPLOYEES: _____ INJURED EMPLOYEE DISTRACTED: _____

DRUG/ALCOHOL: _____ OTHER: _____

ROOT CAUSE OF INJURY (Why did injury/exposure occur?)

RECOMMENDATIONS

ACTION PLAN TO PREVENT RECURRENCE (What can be done to prevent another similar injury?)

ACTION PLAN IMPLEMENTED: yes no **DATE:** _____ **COMPLETED:** yes no **DATE:** ____/____/____

COMMUNICATED RESULTS AND RECOMMENDATIONS

EMPLOYEES: yes no **DATE:** ____/____/____ **OTHER DIVISIONS:** yes no **DATE:** ____/____/____

INVESTIGATOR NAME: (Please print) _____

SIGNATURE: _____

PASS # _____

LOCATION MANAGER/

SIGNATURE: _____

PASS # _____

LOCATION SAFETY OFFICER NAME: (Please print) _____

PHONE # () _____

