ACCIDENT INVESTIGATION FORM

(To be completed and reviewed by employee and immediate supervisor)
This form MUST be completed even if no lost time or injury requiring medical attention

Date of Report: _____
Accident resulted in:

☐ Injury ☐ Illness ☐ Property Damage ☐ Blood/body fluid exposure
☐ First Aid ☐ Medical Treatment ☐ Lost Time ☐ _____

Name of Injured: _____ Department: _____
Job Title: _____ Supervisor: _____
Date of Hire: _____ Length of time at this job: _____
Social Security Number:_____Employee Home Phone Number:_____
Employee Street Address:_____ City:_____ Zip Code: _____
Marital Status:_____ Date of Birth:_____ Shift start time:_____

Date of accident/incident:_____ Time of accident/incident:_____ ○a.m. ○p.m.
Date Reported: _____ Reported to whom: _____
Witnesses: _____
Did Employee miss work? ☐Yes ☐No First day missed: _____ Returned to work on: _____

INJURED PARTY'S STATEMENT:

Describe accident/incident:

What were you doing immediately before the incident occurred?

Identify specific location where accident/incident occurred:

What type of action was taken to immediately treat the injury? (Specify doctor and medical facility name if any):

Have similar accidents occurred before? ☐Yes ☐ No
Reason for recurrence (if any):

How could this accident have been prevented?

INJURY DESCRIPTION:

1. ☐ Amputation
2. ☐ Back strain
3. ☐ Break/fracture
4. ☐ Bruise/abrasion
5. ☐ Burn
6. ☐ Cut/puncture
7. ☐ Dermatitis
8. ☐ Eye Injury
9. ☐ Repetitive motion
10. ☐ Sprain/strain
11. ☐ No apparent injury
12. ☐ Tear
13. ☐ Other: _____

INJURED BODY PART: (Check all that apply – Thumb = Finger 1, Great Toe = Toe 1)

Head & Neck:	Upper Extremities: R / L	Trunk: U / M / L	Lower Extremities: R / L
☐ Skull	☐ Shoulder ☐ ☐	☐ Back ☐ ☐ ☐	☐ Thigh ☐ ☐
☐ Scalp	☐ Arm (Upper) ☐ ☐	☐ Chest	☐ Knee ☐ ☐
☐ Face	☐ Elbow ☐ ☐	☐ Abdomen	☐ Calf/Shin ☐ ☐

☐ Ear
☐ Nose
☐ Mouth, teeth

☐ Forearm ☐☐
☐ Wrist ☐☐
☐ Hand ☐☐

☐ Hips, pelvis
☐ Other _____

☐ Ankle ☐☐
☐ Foot ☐☐
☐ Toe 1 2 3 4 5 ☐☐☐☐☐

☐ Eye
☐ Neck
☐ Other _____

☐ Finger 1 2 3 4 5 ☐☐☐☐☐
☐ Other _____

☐ Other _____

CAUSE OF THE ACCIDENT

(Check all that apply)

Unsafe Act/Condition:

- ☐ Poor housekeeping
- ☐ Materials/tools/process
- ☐ Work practices
- ☐ Hazards not recognized
- ☐ Inadequate safeguarding devices
- ☐ Protective equipment
- ☐ Physical and environmental stresses
- ☐ Exceeding limits (speeds, strengths, etc.)
- ☐ Equipment, machinery
- ☐ Facility/design
- ☐ Unsafe act by another party
- ☐ Other _____

Contributing Factors:

- ☐ Conflicting goals/policies
- ☐ Failure to plan/anticipate
- ☐ Responsibilities not defined
- ☐ Lack of procedures
- ☐ Resources lacking
- ☐ Failure to act/correct
- ☐ Inadequate time
- ☐ Failure to follow procedure
- ☐ Knowledge/skills lacking
- ☐ Horseplay
- ☐ Poor judgment
- ☐ Excessive physical demands
- ☐ Maintenance/inspection/repairs
- ☐ Failure to use appropriate personal protective equipment
- ☐ Inadequate construction/layout
- ☐ Inadequate instructions
- ☐ Inadequate design/safeguarding
- ☐ Inadequate staff
- ☐ Uncooperative subject
- ☐ Other _____

Corrective Action:

Action to be Taken to Prevent Recurrence: _____ Responsible Party: _____ Completion Date: _____

Follow-Up:

Supervisor Recommendations:

Signatures:

Employee: _____ Date: _____

Immediate Supervisor: _____ Date: _____

Department/Division Head: _____ Date: _____

Please forward completed, signed form to Amy Krogman in Administration.

Clear Form Print Save