

ACCIDENT INVESTIGATION FORM

(To be completed and reviewed by employee and immediate supervisor)

Date of Report: _____

Accident resulted in:

- | | | | |
|------------------------------------|--|--|--|
| <input type="checkbox"/> Injury | <input type="checkbox"/> Illness | <input type="checkbox"/> Property Damage | <input type="checkbox"/> Blood/body fluid exposure |
| <input type="checkbox"/> First Aid | <input type="checkbox"/> Medical Treatment | <input type="checkbox"/> Lost Time | |

Name of Injured: _____ Department: _____

Job Title: _____ Supervisor: _____

Total length of employment: _____ Length of time at this job: _____

Date of accident: _____ Time of accident: _____ Select

Date Reported: _____ Reported to whom: _____

Witnesses: _____

INJURED PARTY'S STATEMENT:

Describe accident:

Identify specific location where accident/incident occurred:

What type of action was taken to immediately treat the injury?

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

How could this accident have been prevented?

INJURY DESCRIPTION:

- | | | | |
|---|--|---|---|
| 1. <input type="checkbox"/> Amputation | 5. <input type="checkbox"/> Burn | 9. <input type="checkbox"/> Repetitive motion | 13. <input type="checkbox"/> Other: _____ |
| 2. <input type="checkbox"/> Back strain | 6. <input type="checkbox"/> Cut/puncture | 10. <input type="checkbox"/> Sprain/strain | |
| 3. <input type="checkbox"/> Break/fracture | 7. <input type="checkbox"/> Dermatitis | 11. <input type="checkbox"/> No apparent injury | |
| 4. <input type="checkbox"/> Bruise/abrasion | 8. <input type="checkbox"/> Eye Injury | 12. <input type="checkbox"/> Tear | |

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

- | <u>Head & Neck:</u> | <u>Upper Extremities:</u> | <u>Trunk:</u> | <u>Lower Extremities:</u> |
|---------------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> Skull | <input type="checkbox"/> Shoulder Select | <input type="checkbox"/> Back Select | <input type="checkbox"/> Thigh Select |
| <input type="checkbox"/> Scalp | <input type="checkbox"/> Arm (upper) Select | <input type="checkbox"/> Chest | <input type="checkbox"/> Knee Select |
| <input type="checkbox"/> Face | <input type="checkbox"/> Elbow Select | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Calf/Shin Select |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Forearm Select | <input type="checkbox"/> Hips, pelvis | <input type="checkbox"/> Ankle Select |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Wrist Select | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Foot Select |
| <input type="checkbox"/> Mouth, teeth | <input type="checkbox"/> Hand Select | | <input type="checkbox"/> Toe Select |
| <input type="checkbox"/> Eye | <input type="checkbox"/> Finger Select | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> Other _____ | | | |

CAUSE OF THE ACCIDENT

(Check all that apply)

Unsafe Act/Condition:

- | | |
|--|---|
| <input type="checkbox"/> Poor housekeeping | <input type="checkbox"/> Physical and environmental stresses |
| <input type="checkbox"/> Materials/tools/process | <input type="checkbox"/> Exceeding limits (speeds, strengths, etc.) |
| <input type="checkbox"/> Work Practices | <input type="checkbox"/> Equipment, machinery |
| <input type="checkbox"/> Hazards not recognized | <input type="checkbox"/> Facility/design |
| <input type="checkbox"/> Inadequate safeguarding devices | <input type="checkbox"/> Unsafe act by another party |
| <input type="checkbox"/> Protective equipment | <input type="checkbox"/> Other _____ |

Contributing Factors:

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

Corrective Action:

Action to be Taken to Prevent Recurrence:

Responsible Party:

Completion Date:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Follow-Up:

Supervisor/Safety Committee Recommendations:

Signatures:

Safety Director: _____ Date: _____

Employee: _____ Date: _____

Supervisor: _____ Date: _____

cc: Department Safety Representative