Accident Investigation Report

The unsafe acts of people, and the unsafe conditions that cause accidents, can be corrected only when they are known specifically. This report will help to identify them and correct them. This report and investigation must be completed within 24 hours of the accident. The employee involved and his/her supervisor should cooperate to complete all the information requested. Please use additional paper as necessary.

PART I - General Information:  Dept/Area: ____________________________

Name of Injured: ____________________________  Employee #: ____________________________

PART II – Employee’s Description of Accident (What Happened?)

Day / Date of Accident: ________________  Time: ___  Exact Location: ____________________________

When was supervisor notified? ____________________________  Who did you report the accident to? ____________________________

Job or Activity at Time of Accident: ____________________________

Describe the Accident: ____________________________________________

_____________________________________________________________

_____________________________________________________________

_____________________________________________________________

_____________________________________________________________

Describe the Injury and body part(s) affected: ____________________________________________

_____________________________________________________________

_____________________________________________________________

_____________________________________________________________

Names of on duty supervisor and any witness(es): ____________________________

_____________________________________________________________

_____________________________________________________________

_____________________________________________________________

Employee Signature: ____________________________  Phone #: ____________________________  Date: ____________________________

(I certify that the information provided above is true and complete.)
PART III - Supervisor's Investigation of the Accident: If you do not agree with the employee's report, notify your Human Resources Manager and / or the Office of Workers Compensation immediately, and provide details with this report.

A. Describe any UNSAFE Acts:

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________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

B. Describe any UNSAFE Conditions:

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________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

C. Identify the Cause(s) of the Accident:

________________________________________________________________________

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________________________________________________________________________

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________________________________________________________________________

PART IV - Corrective Action Taken
(What have you done or what do you recommend to prevent a recurrence of a similar accident?)

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________________________________________________________________________

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Has corrective action been taken? ____________ If not, give Reason: __________________________________________

PART V - Accident Analysis Details

Severity of Injury / Damage:

☐ Fatality  ☐ Lost Workdays  ☐ Medical Treatment (off premises)  ☐ First Aid (On site)
☐ Significant Property Damage

Panel of Physicians List Provided to Employee  ☐ Yes – Attach Copy to this report  ☐ No

Employment Category:

☐ Regular, Full-time  ☐ Regular, Part-time  ☐ Temporary  ☐ Contractor  ☐ Other: _______________________

Time in Occupation at time of accident:

☐ Less than 6 months  ☐ 6 mos. to 2 years  ☐ 2 to 5 years  ☐ More than 5 years

Work Shift at time of accident:

☐ Day Shift  ☐ Evening Shift  ☐ Night Shift

Prepared by: (Name & Title)  Work Phone #:  Date Report Prepared: ____________________________

Reviewed by: (Name & Title)  Work Phone #:  Date Report Reviewed: ____________________________

Follow – up Action:

________________________________________________________________________________________

________________________________________________________________________________________

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