ACCIDENT INVESTIGATION FORM

Name of Injured Employee: _____ *SSN:* _____

Age: _____ *Sex:* _____ *Years of Service:* _____ *Time at Present Job:* _____ *Shift:* _____

Occupation: _____ *Department:* _____ *Supervisor:* _____

I. Date of Injury: _____ *Time:* _____ *Date Reported:* _____

Dept. Where Injured: _____ *Exact Location:* _____

Body Part Injured: _____ *Type of Injury:* _____

Describe accident. Include machine, object or substance involved. Use additional paper if necessary: ____

_____

_____

_____

_____

Witnesses: _____

II. First Aid Only: Yes G *No* G *Doctor Visit Required: Yes* G *No* G

Medical Provider Utilized: _____

III. Unsafe Acts: Yes G *No* G

Description: _____

_____

_____

_____

Why was unsafe act committed? _____

_____

Unsafe Conditions: Yes G *No* G

Description: _____

_____

_____

_____

Why did unsafe condition exist? _____

_____

IV. Based on the information provided above (unsafe acts/unsafe conditions) what actions have been taken or recommended to management to prevent reoccurrences?

_____

_____

_____

_____

_____

V. Investigated By: _____ *Dept:* _____ *Date:* _____
Name *Title*

VI. Safety Officer's Comments: _____

_____

Follow-up Action Taken: _____

_____

_____

_____ _____ _____
Department Head *Date* *Immediate Supervisor* *Date* *Safety Officer* *Date*

Exhibit C