GLENN COUNTY
ACCIDENT INVESTIGATION FORM

INJURED EMPLOYEE INFORMATION	
Name:	Title:
Department:	Phone Number
Date of Hire:	Time at Present Job:
Supervisor's Name:	Title:

INCIDENT INFORMATION	
Date of Incident:	Time:
Date Incident Reported:	
Incident Reported To:	Title:
Location of Incident:	
Body Part Injured:	Type of Injury:
What job or activity was the employee performing just prior to the accident?	
Describe Accident. Include machine, object or substance involved. Use additional paper if necessary	
Describe the injury and body part(s) affected:	
Property damage: : Yes ☐ No☐	If yes, specify:

MEDICAL CARE	
First Aid Only: : Yes ☐ No☐	Doctor Visit Required: Yes ☐ No☐
Medical Provider Utilized:	
Number of Lost Workdays (if any):	

SKETCH / DIAGRAM (Use back of paper if more space is needed.)

CAUSAL FACTORS

Describe any Unsafe Acts:

Describe any Unsafe Conditions:

Identify the cause(s) of the incident

WITNESS INFORMATION

Name:	Phone #:
Name:	Phone #:
Name:	Phone #:

CORRECTIVE ACTION INFORMATION

What corrective action has been taken or is recommended to prevent a recurrence of a similar accident?

Has corrective action been completed? Yes ☐ No☐	If yes, date completed:
If no, please give reason:	
Person Responsible for implementing corrective action:	Phone Number:

INVESTIGATION COMPLETED BY

Name:	Date:
Department:	Phone #:
Address:	
Signature:	Title:
Department Safety Representative Signature:	Date:
Department Head Signature	Date:

FOLLOW UP ACTION TAKEN:

Copies to:

Department Office
County Asst. Safety Officer