

ACCIDENT INVESTIGATION FORM

1. Accident Type: Injury/Illness Property Damage Major Potential Fire Spill Other

2. Accident Date (Y/M/D) ____/____/____

3. Time (24 Hour Clock) _____

4. Area: _____

5. Specific Location: _____

INJURY/ILLNESS

6. First Aid Medical Aid Modified Work Lost Time Fatal

7. Name of Employee: _____

8. Shift ____ Age ____ Sex ____

9. Occupation: _____

9.5 Experience: _____

10. Nature of Injury: _____

11. Object/Equipment/substance Inflicting Injury/Damage: _____

12. Person with most control over item(s) in 11 above:

Name: _____

Dept. _____

PROPERTY DAMAGE

13. Description of Property _____

14. Description of Damage _____

15. Estimated Cost _____

OTHER ACTUAL POTENTIAL LOSS

16. Type _____

17. Description _____

18. Estimated Cost _____

19. Evaluation of Risk Potential if Not Corrected

A. Loss Severity Potential Major Serious Minor

B. Probable Recurrence Rate Frequent Occasional Rare

20. Description of Accident: _____

ACCIDENT INVESTIGATION FORM

Diagram of Scene

21. Witness(s): _____

Witness(s) Statement(s) Attached Yes No

22. Immediate Cause(s) _____
Description: _____

23. Underlying Cause(s) _____
Description: _____

24. Corrective Action(s) (Immediate, Interim, Final): _____

25. Date Report Completed: (Y/M/D) ____/____/____

Signatures

Supervisor: _____

Employee: _____