ACCIDENT/INCIDENT INVESTIGATION FORM

Company_______________________________________Address ____

Department_____________________________________Location (if different from above) _________________________________

1. **Name of injured employee**____2. **Gender** Male Female
3. **Social Security Number**__________-______-____________ 4. **Age** ______ 5. **Date of accident**____/____/_____
6. **Home address**_____________________________**City**________________________**State**_______**Zip** _____________
7. **Employee's usual occupation**________________________8. **Occupation at time of accident**_____________________
9. **Length of employment** < 1 month one to five months six months to five years five+ years
10. **Time in occupation at time of accident** < 1 month one to five months six months to five years five+ years
11. **Employment category** Regular, full-time Regular, part-time Temporary Seasonal Non-employee
12. **Case numbers and names of others injured in same accident**

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13. **Nature of injury and parts of body** ____
14. **Name and address of physician** ____
15. A. **Time of injury**_____:_________M B. **Time within shift?** Yes No C. **Type of shift** _______________________
16. **Severity of injury** Requires medical treatment ______Days away from work ______Days of restricted activity

    Fatality First Aid Other ____
17. **Name and address of hospital** ____
18. **Phase of employee's work day at time of injury** During rest period Entering or leaving plant During meal period

    Performing work duties Working overtime Other (specify) ____
19. **Did accident occur on employer premises?** Yes No
20. **Describe how the accident occurred** ____

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21. **Accident sequence.** *Describe, in reverse order of occurrence, the events preceding the accident/injury. Begin with the injury and move back in time, reconstructing the sequence of events that led to the injury (e.g., A. injury event; B. accident event; C. preceding event #1; D. preceding event #2, etc.).* ______________________________

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22. **Task and activity at time of accident**

A. General type of task______________________ B. Specific activity ______________________

C. Employee was working alone with crew or fellow worker Other ______________________

23. **Posture of employee** ______________________________

24. **Supervision at time of accident** Directly supervised Indirectly supervised Not supervised Supervision not feasable

25. **Casual factors -** *Describe events and conditions that contributed to the accident.* ______________________

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26. **Corrective actions -** *Describe actions that have been, or will be taken, to prevent recurrence.* ______________________

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Prepared by______________________________**Title** ______________________

Department______________________________**Date**_____/____/________

Employee signature______________________**Title**______________**Date**_____/____/________

Approved by______________________**Title**______________**Date**_____/____/________