



INCIDENT INVESTIGATION FORM

EMPLOYEE INFORMATION

Last Name:	First Name:	Middle Name:
Department/Division:		
Job Title:		

HUMAN RESOURCES ONLY

Address:			
City:		State:	Zip:
SSN:	Phone:	Age:	Sex:
DOB:	Hire Date:	Marital Status:	Dependents:

INCIDENT DESCRIPTION

Date of Incident:	Time of Incident: <div style="text-align: center;">AM / PM</div>	Date Reported:	Time Reported: <div style="text-align: center;">AM / PM</div>
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When Did Incident Occur: Within 1st Hour of Work Between 2nd and 8th Hour After 8th Hour of Work

Length of Time on Job: In Training Less Than 1 Year More Than 1 Year

Explain what occurred including all events that led up to and occurred during the event. Include exact location, machine numbers, etc.

Were there any witnesses? YES NO If yes, who?

Was a 3rd party (i.e. subcontractor) directly or indirectly involved? YES NO

Was safety equipment bypassed, not used or improperly used? YES NO

Was medical attention offered? YES NO If yes, check all that apply:

1st Aid On Site Occupational Health Clinic/Name: Hospital Emergency Room/Name:

Employee does not wish to receive outside medical treatment at this time. Other:



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INCIDENT TYPE

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Strain While Lifting
or Moving Object | <input type="checkbox"/> Fall, Same Level | <input type="checkbox"/> Slip or Trip (no fall) | <input type="checkbox"/> Struck Against Object |
| <input type="checkbox"/> Struck by Object | <input type="checkbox"/> Caught In, Under or Between | <input type="checkbox"/> Overexertion/Strain | <input type="checkbox"/> Motor Vehicle |
| <input type="checkbox"/> Forklift or Pallet Jack | <input type="checkbox"/> Other (explain) _____ | | |

BODY PART(S) AFFECTED (circle left or right where applicable)

- | | | | | |
|--|--------------------------------------|--|---|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Hip (Lt./Rt.) | <input type="checkbox"/> Wrist (Lt./Rt.) | <input type="checkbox"/> Shin/Calf (Lt./Rt.) |
| <input type="checkbox"/> Face | <input type="checkbox"/> Trunk/Torso | <input type="checkbox"/> Shoulder (Lt./Rt.) | <input type="checkbox"/> Hand (Lt./Rt.) | <input type="checkbox"/> Ankle (Lt./Rt.) |
| <input type="checkbox"/> Lip/Mouth | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Upper Arm (Lt./Rt.) | <input type="checkbox"/> Finger (Lt./Rt.) | <input type="checkbox"/> Foot (Lt./Rt.) |
| <input type="checkbox"/> Eye (Lt./Rt.) | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Elbow (Lt./Rt.) | <input type="checkbox"/> Thigh (Lt./Rt.) | <input type="checkbox"/> Toe (Lt./Rt.) |
| <input type="checkbox"/> Ear (Lt./Rt.) | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Forearm (Lt./Rt.) | <input type="checkbox"/> Knee (Lt./Rt.) | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Other (explain) _____ | | | | |

NATURE OF INJURY/ILLNESS

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Sprain/Strain | <input type="checkbox"/> Fracture/Dislocate/Crush | <input type="checkbox"/> Foreign Object | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Repetitive Trauma (CTDs) | <input type="checkbox"/> Skin Irritation/Dermatitis | <input type="checkbox"/> Heat Stress | <input type="checkbox"/> Chemical Exposure |
| <input type="checkbox"/> Cut/Scrape/Puncture | <input type="checkbox"/> Burn-Thermal/Electrical | <input type="checkbox"/> Hernia/Rupture | <input type="checkbox"/> Amputation |
| <input type="checkbox"/> Bruise/Contusion | <input type="checkbox"/> Burn-Chemical | <input type="checkbox"/> Other (explain) _____ | |

BASIC CAUSE(S) (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Unsafe Method Used | <input type="checkbox"/> Housekeeping/Clutter | <input type="checkbox"/> Procedure Not Followed Properly |
| <input type="checkbox"/> Spills/Leaks | <input type="checkbox"/> Using Improper Tool | <input type="checkbox"/> Lack of Protective Equipment |
| <input type="checkbox"/> Shortcuts/Save Time | <input type="checkbox"/> Unguarded/Faulty Equipment | <input type="checkbox"/> Other (explain) _____ |

ROOT CAUSE(S) (check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Lack of Procedure | <input type="checkbox"/> Lack of Enforcement/Motivation | <input type="checkbox"/> Inadequate Inspection/Maintenance |
| <input type="checkbox"/> Inadequate Procedure | <input type="checkbox"/> Lack of Knowledge/Training | <input type="checkbox"/> Other (explain) _____ |

CORRECTIVE ACTION

Action Needed	Person(s) Responsible	Expected Completion Date

REQUIRED SIGNATURES

Employee Signature:		Date:
Supervisor Signature:		Date:

Please return this form to the Human Resources Administrator within 72 hours of the incident.