

Accident Investigation Report

The unsafe acts of people, and the unsafe conditions that cause accidents, can be corrected only when they are known specifically. It's your responsibility to **identify** them and **correct** them. This report and investigation **must be completed within 24** hours of the accident. The employee involved and his/her supervisor should cooperate to complete all the information requested. Please use additional paper as necessary.

PART I - General Information: Agency Location Code _____ Dept/Area _____

Name of Injured _____ Social Sec. # _____

PART II - Employee's Description of Accident (What Happened ?)

Day/Date of Accident _____ Time _____ Exact Location _____

When was supervisor notified? _____ Who did you report the accident to _____

Job or Activity at Time of Accident: _____

Describe the Accident: _____

Describe the injury and body part(s) affected: _____

Names of on duty supervisor and any witness(es): _____

Employee Signature _____ Phone # _____ Date: _____

(I certify that the information provided above is true and complete.)

PART III - Supervisor's Investigation of the Accident: If you do not agree with the employees report notify your Human Resources Manager and I or the Office of Workers Compensation immediately, and provide details with this report.

A. Describe any UNSAFE Acts: _____

B. Describe any UNSAFE Conditions _____

C. Identify the Causes) of the Accident : _____

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PART IV - Corrective Action Taken

(What have you done or what do you recommend to prevent a recurrence of a similar accident ?)

Has it been done ? _____ If not, give reason _____

PART V - Accident Analysis Details

Severity of Injury / Damage

- Fatality Lost Workdays Medical Treatment (off premises) First Aid (On site)
 Significant Property Damage

Panel of Physicians List Provided to Employee Yes -Attach Copy to this report No

Employment Category:

- Regular, Full-time Regular, Part-time Temporary Contractor Other: _____

Time in Occupation at time of accident

- Less than 6 months 6 mos To 2 years 2 to 5 years More than 5 years Work

Shift at time of accident

- Day Shift Evening Shift Night Shift

Prepared by: (Name & Title)	Work Phone #:	Date Report Prepared.
Reviewed by- (Name & Tithe)	Work Phone #:	Date Report Reviewed:

Follow - up Action:
