

**COMPLETE WITHIN
12 HOURS OF
ACCIDENT OR
ONSET OF
SYMPTOMS**

Accident Investigation *Employee Incident Report Form*

Sections 1 through 4 to be completed by injured employee
Section 5 to be completed by employee supervisor

Section 1 – Type of Occurrence

- Injury or Illness
 Near Miss
 Facility Damage

Section 2 - Employee information

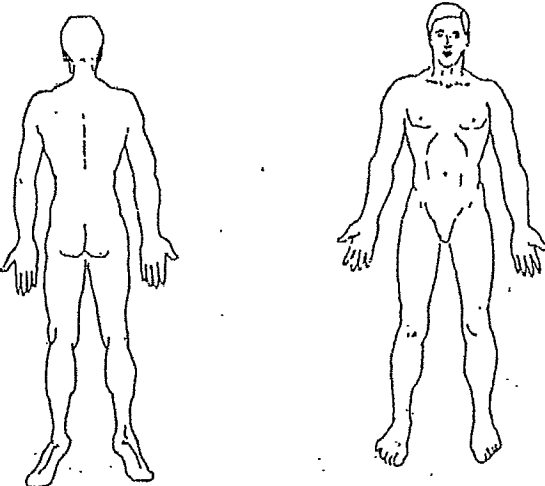
Employee name		Home phone number ()	
Job Title	Department		Shift
Social security number	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of hire

Section 3 - Medical Treatment

Medical Facility / Physician		Phone number ()	
Address	Treated in Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fatality? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 4 - Occurrence information

Circle on the diagram location of injury



Type of Injury (circle)

1. Strain/Sprain
2. Pain/Soreness
3. Laceration
4. Bruise
5. Pulled Muscle
6. Scratch/Abrasion
7. Burn
8. Swelling
9. Bite
10. Irritation
11. None apparent
12. Fracture
13. Other _____

Employee Signature

Describe how the accident occurred (what happened before, during and after the accident)	Date and Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM
	Time Shift Began <input type="checkbox"/> AM <input type="checkbox"/> PM
	Date and Time Reported <input type="checkbox"/> AM <input type="checkbox"/> PM
	Have you ever injured this part of your body before <input type="checkbox"/> Yes <input type="checkbox"/> No

Were you performing a regular job task when the accident occurred <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been trained to perform the this job <input type="checkbox"/> Yes <input type="checkbox"/> No
Location of accident	Equipment involved
Who else was involved in the accident	
Who saw or helped you when the accident occurred	
How could this accident be prevented in the future	
Employee Signature	Date

Section 5 – Supervisor Analysis

<input type="checkbox"/> Employee portion of form completed	<input type="checkbox"/> Employee indicated body part injured and signed at bottom of picture
<input type="checkbox"/> Witness statements attached	<input type="checkbox"/> Interviewed witnesses and / or reviewed statements
<input type="checkbox"/> If equipment was involved, reviewed equipment maintenance records	<input type="checkbox"/> Maintenance has been notified of equipment problems (i.e. missing guards, faulty operation, etc)
<input type="checkbox"/> When was employee last trained related to procedure or equipment related to this accident	<input type="checkbox"/> Work restrictions received
<input type="checkbox"/> Photographs attached	<input type="checkbox"/>
ACCIDENT CAUSAL FACTORS	CORRECTIVE ACTIONS
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
ROUTING (SIGNATURES)	
1) Employee Supervisor	Date
2) Human Resources / Safety Manager	Date
3) Plant Manager / CEO	Date
Revised May 21, 2007	

STATEMENT OF WITNESS TO ACCIDENT

Employer:

I. INCIDENT IDENTIFICATION INFORMATION

Name of employee alleging incident _____ Shift _____
Occupation _____ Department _____

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your name _____ Your occupation _____
Your address _____ Your telephone number () _____ - _____

Did you see an accident involving the above employee? Yes No
If not, how did you learn about the accident? _____

If you did see an accident occur: Date of accident _____ Time of accident _____ am pm

Describe what you saw: _____

Your signature _____ Please print your name _____ Date _____
