

ACCIDENT/INJURY/ILLNESS INVESTIGATION REPORT

(FORM TO BE USED TO DOCUMENT NEAR MISSES ALSO)

Employee Name:		Date of Injury/Illness: / /	
Social Security #:		Department:	
Employee Required: <input type="checkbox"/> First-Aid Only <input type="checkbox"/> Medical Treatment <input type="checkbox"/> Fatality / / (date of death) <input type="checkbox"/> OSHA Recordable			
<input type="checkbox"/> Completed Industrial Commission Form 19 and forwarded copies to Human Resource Services and Office of Safety?		<input type="checkbox"/> Attached "Attending Physician Form" from Student Health Service?	
<input type="checkbox"/> Went to Gove Student Health Center? If not why?		<input type="checkbox"/> Will follow-up or referral treatment be needed? If so, where?	
<input type="checkbox"/> Injury/Illness caused employee to miss work or to have restricted duties?		<input type="checkbox"/> Date employee is expected to return to work / /	
		<input type="checkbox"/> Date employee is to be off restricted work / /	
Location of Accident (specify site):			
Witnesses Name:		Telephone Number: () -	
PROPERTY DAMAGE <input type="checkbox"/> Does not apply <input type="checkbox"/> Major <input type="checkbox"/> Serious <input type="checkbox"/> Minor [] Vehicle [] Equipment [] Private Property			
Vehicle I.D.:		Equipment I.D.:	
Model:	Model:	Type:	Age: (yrs)
Age: (yrs)	Age: (yrs)		
Driver's License #:	Exp: / /		
Employee Description of Accident/Incident (to be completed by injured/ill employee):			
Describe injury/illness:			
How did it happen?			
(use separate sheet, if additional space is needed)			
Employee's Signature:		Telephone: () - Date: / /	
Name & Title of person most directly responsible for employee involved in accident (Supervisor):			
Name:		Title:	
		Telephone: () - Date: / /	
IMMEDIATE CAUSE(s)		Explain:	
<input type="checkbox"/> Equipment <input type="checkbox"/> Personnel <input type="checkbox"/> Environment <input type="checkbox"/> Mgt. <input type="checkbox"/> Hazardous Conditions <input type="checkbox"/> Unsafe Act			
BASIC CAUSE & CONTRIBUTING FACTOR(s)		Explain:	
<input type="checkbox"/> Environmental conditions <input type="checkbox"/> Personnel <input type="checkbox"/> Hazardous conditions <input type="checkbox"/> Management <input type="checkbox"/> Lack of safety instruction & training			
CORRECTIVE ACTION:		Explain:	
I have taken the following, <input type="checkbox"/> Temporary / <input type="checkbox"/> Permanent immediate actions to reduce recurrence.			
I recommend the following action(s) to prevent recurrence; and anticipate completion by: / /			
Department Head's Comments: (Appropriateness of Cause & Corrective Action)		Signature: _____	
		Title:	
		Telephone: () - Date: / /	
Corrective Action/Follow up By Department Head:		Date: / /	
Reviewed by Office of Safety:		Date: / /	