

Accident Investigative Report

The supervisor with the assistance of the injured worker and witnesses shall complete this form.

Employee name: _____ Age: _____ Social Security number: _____

Department: _____ Job title: _____ Shift: _____

Date/Time injury reported: _____ Date/Time of injury: _____

Witness name(s): _____ (Please attach signed statements)

Accident location: _____

Describe the accident and the specific part(s) of the body that were injured:

Describe the task being performed when the accident occurred (specify any tools or equipment being used, the specific task being performed, other people involved, body position, etc.):

List each factor contributing to accident (e.g., time, space, environment, staffing, equipment malfunction, surprise occurrences, etc.) and how each factor contributed:

1. _____

2. _____

3. _____

4. _____

How long has employee performed this job? ___ years. ___ months.

If less than one year, previous employer _____

Has employee had any previous injuries of this nature? Yes No

If so, when? _____ Claim number _____

Have any other employees been injured doing this task? Yes No

Who/When: _____

Is this task a regular part of the employee's job duties? Yes No

If not, whose? _____

Was the employee trained on how to perform this task? Yes No

When? _____ By whom? _____

Was employee following established safety procedures? Yes No

If not, explain: _____

Additional comments: _____

Completed by: _____ Title: _____ Date: _____