Incident Investigation Report

EMPLOYEE INFORMATION							
Last Name		First Name		MI		USD ID#	
Address		City/State/Zip					
Department		Supervisor's Name					
Home Phone		Work Phone		Supervisor's Phone			

EMPLOYEE STATEMENT					
Type of Incident		Location of Incident		Date & Time	
Medical Treatment Required or Requested? YES ☐ NO ☐	If so, Diagnosis?				
Injury Classification: Lost Time ☐ First Aid Only ☐ Medical Only ☐ Incident Only ☐					
Was the employee made aware of hazards and proper Safe Work Practices associated with the task before the incident? YES ☐ NO ☐					
Describe in detail how the incident occurred. Include specific activities, equipment, materials, and people involved.					
What workplace condition, work practice, or lack of protective equipment contributed to the incident?					
Employee Signature		Date			

WITNESS STATEMENT						
Witness Name		Statement Obtained? YES ☐ NO ☐	Date			
Witness Name		Statement Obtained? YES ☐ NO ☐	Date			
Did the witness know the proper Safe Work Practices to prevent injury? YES ☐ NO ☐	Is this policy enforced? YES ☐ NO ☐					
How were they trained?	Safety Topic		Instructor		Date	
Have they observed injured employee performing this task prior to the injury? YES ☐ NO ☐						
Was it being performed correctly at the time? YES ☐ NO ☐	Was the supervisor aware of this information? YES ☐ NO ☐					

INVESTIGATOR STATEMENT		
What was the injury, illness, or exposure?		Was a mandatory Safe Work Practice violated? YES ☐ NO ☐
What physical, mechanical, or environmental conditions contributed to this accident?		

EMPLOYEE TRAINING AND RECORDS REVIEW

How was the employee instructed to perform the job correctly?

Training/Orientation ☐ Safe Work Practices ☐ Manuals ☐ Verbally ☐ Post-Accident ☐

Safety Topic		Instructor		Date	
Safety Topic		Instructor		Date	

EQUIPMENT RECORDS REVIEW

Equipment Name		Serial			
Last Inspection/ Maintenance Performed		By		Date	

INITIAL CAUSE

- ☐ Struck by or against object: ________________
- ☐ Caught in/ under/between
- ☐ Fall/Slip/Trip
- ☐ Material handling or lifting
- ☐ Repetitive motion
- ☐ Chemical Exposure
- ☐ Bodily Fluid exposure
  - ☐ Needle Stick
  - ☐ Sharps
  - ☐ Other
- ☐ Other, explain: ____________________ ____________________

CONTRIBUTING FACTORS AND ACTIVITIES

Equipment
- ☐ Equipment failure
- ☐ Equipment unavailable
- ☐ Improper equipment or material used: ____________________

Personal Protective Equipment
- ☐ Not worn
- ☐ Not readily available
- ☐ Not adequate for the task
- ☐ Personal Protective Equipment failure

Training/Experience
- ☐ Lack of training
- ☐ Safety training not followed
- ☐ Lack of policy/procedure
- ☐ Lack of experience for task

Work Area
- ☐ Work area set up improperly
- ☐ Inadequate light or noise
- ☐ Housekeeping issues
- ☐ Environmental Factors (rain, wind, temp, etc)
- ☐ Ventilation issues
- ☐ Ergonomic factors

Employee
- ☐ Physically unable to do work
- ☐ Employee fatigue
- ☐ Unbalanced or poor position or motion
- ☐ Incorrect procedures used
- ☐ Other unsafe practice

Assistance
- ☐ Difficult to perform task without help
- ☐ Safety features or devices not readily available
- ☐ Assistive devices not used

☐ Other, explain: ____________________ ____________________

PREVENTATIVE ACTIONS

Has this accident identified any areas in need of additional focus? YES ☐ NO ☐

Area		Focus	

SUPERVISOR WILL:
- ☐ Develop/revise safety procedures and update IIPP or CHP
- ☐ Request Ergonomic evaluation
- ☐ Order new equipment: ____________________
- ☐ Remove equipment from use to repair/replace
- ☐ Schedule preventative maintenance
- ☐ Perform on-site review of work activity, update Job Safety Analysis
- ☐ Schedule additional training: ____________________
- ☐ Reconfigure work area
- ☒ Communicate corrective actions to others in job category
- ☐ Other: ____________________

PREVENTATIVE ACTIONS WILL BE COMLETED BY: ____________________

EXPECTED DATE OF COMPLETION: ____________________

NOTES: ____________________ ____________________

INCIDENT INVESTIGATION COMPLETED BY:

Employee's Supervisor		Date	

INCIDENT INVESTIGATION APPROVED AND REVIEWED BY:

Department Head's Signature		Date	