Employee Accident Investigation Report

This form MUST be completed by the employee's supervisor if medical attention is required.

This is a Word Document to be completed electronically.

Name of Injured Employee		**Date/Time of Incident**	
Job Title		**YRS Experience**	
Specific Location of Accident			
Witness Name (1)		**Witness Name (2)**	
Type or Nature of Injury		**Body Part Injured**	
Medical Attention Received		**Were**	
Describe in detail the accident and how it occurred (what was the employee doing, what objects or substances involved, actions, movements):			

	YES	NO	N/A
Personal Protective Equipment (PPE) required, provided, and used?	☐	☐	☐
Safe operating procedures provided for task?	☐	☐	☐
Employee provided training in safe operating procedures / use of PPE?	☐	☐	☐
Proper tools and/or equipment provided to safely perform task?	☐	☐	☐

Cause of Accident (carelessness is not an acceptable cause):

Prevention:

Corrective action to prevent reoccurrence (changes in procedures, tools/equipment, training/re-training, disciplinary action, etc

Report Prepared by: (Supervisor)		**Date**	
Management Review By:		**Date**	
Corrective Action Completed by:		**Date**	

Send completed form to Chris Henry as a pdf for review by the Workers Comp Safety Committee