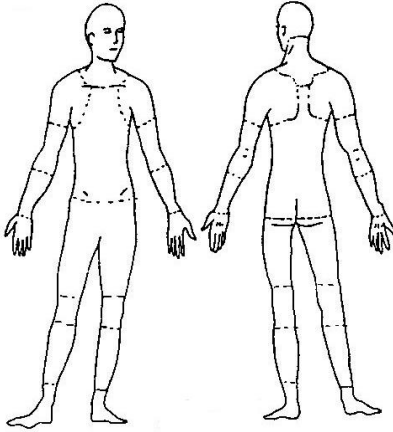


REPORT No.

PLANT/TRUCK No.

# ACCIDENT INVESTIGATION REPORT

**Instructions:** Complete this form as soon as possible after an incident that results in serious injury or illness. (Optional: Use to investigate a minor injury or near miss that *could have resulted in a serious injury or illness.*)

This is a report of a: <input type="checkbox"/> Death <input type="checkbox"/> Lost Time <input type="checkbox"/> Dr. Visit Only <input type="checkbox"/> First Aid Only <input type="checkbox"/> Near Miss		
Date of incident:	This report is made by: <input type="checkbox"/> Employee <input type="checkbox"/> Supervisor <input type="checkbox"/> Team <input type="checkbox"/> Other _____	
<b>Step 1: Injured employee (complete this part for each injured employee)</b>		
Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:
Department:	Job title at time of incident:	
Part of body affected: (shade all that apply)	Nature of injury: (most serious one)	SSN or Employee Number:
	<input type="checkbox"/> Abrasion, scrapes <input type="checkbox"/> Amputation <input type="checkbox"/> Broken bone <input type="checkbox"/> Bruise <input type="checkbox"/> Burn (heat) <input type="checkbox"/> Burn (chemical) <input type="checkbox"/> Concussion (to the head) <input type="checkbox"/> Crushing Injury <input type="checkbox"/> Cut, laceration, puncture <input type="checkbox"/> Hernia <input type="checkbox"/> Illness <input type="checkbox"/> Sprain, strain <input type="checkbox"/> Damage to a body system: <input type="checkbox"/> Other _____	<input type="checkbox"/> Regular full time <input type="checkbox"/> Regular part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary
		Months with this employer:  Months doing this job:
<b>Step 2: Describe the incident</b>		
Exact location of the incident:		Exact time:
What part of employee's workday? <input type="checkbox"/> Entering or leaving work <input type="checkbox"/> Doing normal work activities <input type="checkbox"/> During meal period <input type="checkbox"/> During break <input type="checkbox"/> Working overtime <input type="checkbox"/> Other _____		
Names of witnesses (if any):		
Written witness statements attached? [Y] [N]	Photographs attached? [Y] [N]	Maps / drawings attached? [Y] [N]
What personal protective equipment was being used (if any)?		
Describe, step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials and other important details.		
Description continued on attached sheets: <input type="checkbox"/>		

REPORT No.	PLANT/TRUCK No.
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**Step 3: Why did the incident happen?**

Unsafe workplace conditions: (Check all that apply) <input type="checkbox"/> Inadequate guard <input type="checkbox"/> Unguarded hazard <input type="checkbox"/> Safety device is defective <input type="checkbox"/> Tool or equipment defective <input type="checkbox"/> Workstation layout is hazardous <input type="checkbox"/> Unsafe lighting <input type="checkbox"/> Unsafe ventilation <input type="checkbox"/> Lack of needed personal protective equipment <input type="checkbox"/> Lack of appropriate equipment / tools <input type="checkbox"/> Unsafe clothing <input type="checkbox"/> No training or insufficient training <input type="checkbox"/> Other: _____	Unsafe acts by people: (Check all that apply) <input type="checkbox"/> Operating without permission <input type="checkbox"/> Operating at unsafe speed <input type="checkbox"/> Servicing equipment that has power to it <input type="checkbox"/> Making a safety device inoperative <input type="checkbox"/> Using defective equipment <input type="checkbox"/> Using equipment in an unapproved way <input type="checkbox"/> Unsafe lifting <input type="checkbox"/> Taking an unsafe position or posture <input type="checkbox"/> Distraction, teasing, horseplay <input type="checkbox"/> Failure to wear personal protective equipment <input type="checkbox"/> Failure to use the available equipment / tools <input type="checkbox"/> Other: _____
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Why did the unsafe conditions exist?

Why did the unsafe acts occur?

Is there a reward (such as “the job can be done more quickly”, or “the product is less likely to be damaged”) that may have encouraged the unsafe conditions or acts?  Yes  No  
 If yes, describe:

Were the unsafe acts or conditions reported prior to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have there been similar incidents or near misses prior to this one? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Step 4: How can future incidents be prevented?**

**What changes do you suggest to prevent this incident/near miss from happening again?**

Stop this activity   
  Guard the hazard   
  Train the employee(s)   
  Train the supervisor(s)  
 Redesign task steps   
 Redesign work station   
 Write a new policy/rule   
 Enforce existing policy  
 Routinely inspect for the hazard   
 Personal Protective Equipment   
 Other: \_\_\_\_\_

What should be (or has been) done to carry out the suggestion(s) checked above?

Description continued on attached sheets:

**Step 5: Who completed and reviewed this form? (Please Print)**

Written by:	Date:
Names of investigation team members:	
Reviewed by:	Date: