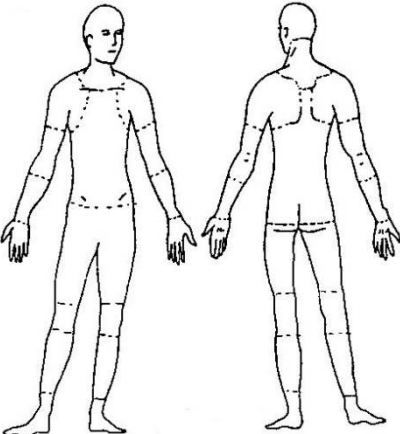


Incident Investigation Report

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 property damage 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"/> Property Damage	
Date of incident:	This report is made by: <input type="checkbox"/> Employee <input type="checkbox"/> Supervisor <input type="checkbox"/> Team <input type="checkbox"/> Other _____

Step 1: Injured employee (complete this part for each injured employee)

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) <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 _____	This employee works: <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:

Step 2: Describe the incident

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"/>	

Names of witnesses (if any):			
Number of attachments :	Written witness statements:	Photographs:	Maps / drawings:
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 attached sheets: <input type="checkbox"/>			

Step 3: Why did the incident happen?	
<p>Unsafe workplace conditions: (Check all that apply)</p> <ul style="list-style-type: none"> <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: _____ 	<p>Unsafe acts by people: (Check all that apply)</p> <ul style="list-style-type: none"> <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: _____
Why did the unsafe conditions exist?	

Why did the unsafe acts occur?	
Is there an attitude (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 <input type="checkbox"/> No <input type="checkbox"/> 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

Step 4: How can future incidents be prevented?	
What changes do you suggest to prevent this incident from happening again?	
<input type="checkbox"/> Stop this activity <input type="checkbox"/> Guard the hazard <input type="checkbox"/> Train the employee(s) <input type="checkbox"/> Train the supervisor(s)	
<input type="checkbox"/> Redesign task steps <input type="checkbox"/> Redesign work station <input type="checkbox"/> Write a new policy/rule <input type="checkbox"/> Enforce existing policy	
<input type="checkbox"/> Routinely inspect for the hazard <input type="checkbox"/> Personal Protective Equipment <input type="checkbox"/> Other: _____	
What should be (or has been) done to carry out the suggestion(s) checked above?	
Continue description on attached sheets: <input type="checkbox"/>	

Step 5: Who completed and reviewed this form? (Please Print)	
Written by:	Title:
Department:	Date:
Names of investigation team members:	
Reviewed by:	Title:
	Date: