

Accident Investigation Form

Date of incident:		Name of employee involved in incident:	
Person completing the form:			
Building:	Job title at time of incident:		
Brief description of the incident, including events that led up to the injury. Include names of any machines, parts, objects, tools, materials and other important details.:			
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):			
What personal protective equipment was being used (if any)?			
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"/> Student to staff accident <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?			
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	
What changes do you suggest to prevent this incident/near miss 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: _____			
Signature:		Date:	