Accident Investigation Report

The unsafe acts of people, and the unsafe conditions that cause accidents, can be corrected only when they are known specifically. This report will help to **identify** them and **correct** them. This report and investigation **must be completed within 24 hours of the accident**. The employee involved and his/her supervisor should cooperate to complete **all** the information requested. Please use additional paper as necessary.

PART I - General Information: Agency Location Code _____ Dept/Area _____

Name of Injured _____ Social Sec. # _____

PART II – Employee's Description of Accident (What Happened?)

Day / Date of Accident _____Time ____ Exact Location _____

When was supervisor notified? _____Who did you report the accident to? _____

Job or Activity at Time of Accident: _____

Describe the Accident: _____

_____

Describe the Injury and body part(s) affected: _____

_____

Names of **on duty** supervisor and any **witness**(es):_____

_____

Employee Signature: _____Phone #_____Date:_____

(I certify that the information provided above is true and complete.)

PART III – Supervisor's Investigation of the Accident: If you **do not agree with the employee's report**, notify your Human Resources Manager and / or the Office of Workers Compensation immediately, and provide details with this report.

A. Describe any UNSAFE Acts: _____

_____

_____

B. Describe any UNSAFE Conditions: _____

_____

_____

C. Identify the Cause(s) of the Accident: _____

_____

_____

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PART IV - Corrective Action Taken

(What have you done or what do you recommend to prevent a recurrence of a similar accident?)

_____

_____

_____

_____

Has it been done? _____ If not, give reason_____

_____

PART V – Accident Analysis Details

Severity of Injury / Damage:

☐ Fatality ☐ Lost Workdays ☐ Medical Treatment (off premises) ☐ First Aid (On site)
☐ Significant Property Damage

Panel of Physicians List Provided to Employee ☐ Yes – Attach Copy to this report ☐ No

Employment Category:

☐ Regular, Full-time ☐ Regular, Part-time ☐ Temporary ☐ Contractor ☐ Other: _____

Time in Occupation at time of accident:

☐ Less than 6 months ☐ 6 mos. to 2 years ☐ 2 to 5 years ☐ More than 5 years

Work Shift at time of accident:

☐ Day Shift ☐ Evening Shift ☐ Night Shift

Prepared by: (Name & Title)	Work Phone #:	Date Report Prepared:
Reviewed by: (Name & Title)	Work Phone #:	Date Report Reviewed:

Follow – up Action:

_____

_____

_____

_____

_____