Accident Investigation Form

To be completed by the Supervisor of the Injured Employee

Name of Injured Employee			Job Title	
Name of Person Conducting this Accident Investigation			Job Title	
Date & Time of Accident			Date of Investigation	
Location of Accident (jobsite name & address)				
Witness(es): ☐ Written Statements Attached				
Description of Injury/Medical Response				

Work activity at the time of the accident?

What task was being performed?

Incident Description

What happened?

Accident Investigation Form

Pre-Task Planning

Was a Job Hazard Analysis / Toolbox Talk completed?
☐ Yes ☐ No
If yes, date: _____

CONTRIBUTING FACTORS

In your opinion did any of these factors play a role in this accident? Please explain or provide detail for all answers other than "A, Not at all"	**A Not at all**	**B Possibly**	**C Definitely**
PPE not used	☐	☐	☐
Fall protection procedures not followed	☐	☐	☐
Misuse of tools or equipment	☐	☐	☐
Faulty or damaged tool or equipment	☐	☐	☐
More safety training needed	☐	☐	☐
Unsafe job conditions	☐	☐	☐
Distraction/Lack of Situational Awareness	☐	☐	☐
Improper Body Positions	☐	☐	☐
Poor Planning/ Pre-task Review?	☐	☐	☐

Causes of the accident:

Was the right equipment being used? ☐yes ☐no Other _____
Was the equipment in good condition? ☐yes ☐no Other _____
Was the correct material or tools being used? ☐yes ☐no Other _____
Was the employee experienced at the task? ☐yes ☐no Other _____
Was the employee following procedures? ☐yes ☐no Other _____
Was the job properly supervised? ☐yes ☐no Other _____
Was the employee a repeat injury? ☐yes ☐no Other _____
Was the employee suited for the job? ☐yes ☐noOther _____

Unsafe Conditions (check all that apply)

☐ Inadequate guarding
☐ Lack of guarding
☐ Defective equipment
☐ Unsafe design
☐ Unsafe loading, stacking, rigging
☐ Inadequate lighting
☐ Inadequate ventilation
☐ Poor housekeeping
☐ Unsafe footing
☐Control failure
☐ Other _____

Unsafe Acts (check all that apply)

☐ Improper lifting, pushing, pulling
☐ Handling
☐ PPE not provided
☐ Failure to wear PPE
☐ Inattention/distracted
☐ Horseplay
☐ Failure to stay clear
☐ Failure to secure
☐ Improper tool usage
☐ Operating without authority
☐ Other _____

WITNESS STATEMENT

Name _____ Phone _____

Occupation/Position: _____

Relationship to injured employee: _____

How long have you worked with the employee: _____

Specifically, what did you observe the employee doing at the time of the accident:

What were you doing at the time, and did you see the accident?

Where were you standing in relation to the incident?

In your opinion, why do you think the incident happened?

Who was directing the activity? _____

_____ _____

Witness Signature **Date**

POST ACCIDENT REVIEW

TO BE COMPLETED BY SAFETY DIRECTOR

Root Cause Analysis

Primary Cause: _____

Secondary Cause: _____

Systemic Cause: _____

Corrective Measures & Accident Prevention:

Responsible Person: _____ **Target Date:** _____

Verified By: _____ Date: _____

OSHA Recordability Determination

To be completed by Human Resources

☐ First Aid Only
☐ OSHA Recordable
☐ Restricted Duty
☐ Lost Time
☐ Hospital / ER Visit

Management Final Review Notes

Manager Name: _____ Title: _____

Signature: _____ Date: _____