



INCIDENT INVESTIGATION REPORT

THIS COMPLETED FORM MUST BE SUBMITTED WITHIN 24 HRS OF THE INCIDENT

Date of Incident: _____ Time of Incident: _____

Location: _____

Did the incident result in injury/illness? **yes** **no** if yes, complete Employee Accident Report

Name(s) of Individual(s) Involved

Occupation(s)

Other Witnesses (if any): _____

WHAT WORKSITE CONDITION CONTRIBUTED TO INCIDENT? check all that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Close clearance/congestion | <input type="checkbox"/> Floors obstruction/foreign substances | <input type="checkbox"/> Inadequate housekeeping |
| <input type="checkbox"/> Hazardous placement | <input type="checkbox"/> Inadequate ventilation | <input type="checkbox"/> Defective equipment/tools/vehicle |
| <input type="checkbox"/> Inadequate lighting | <input type="checkbox"/> Inadequate guards/barriers | <input type="checkbox"/> None/Not Applicable |
| <input type="checkbox"/> Inadequate PPE | <input type="checkbox"/> Other (specify below): | |

WHAT ACTION OR INACTION CONTRIBUTED TO THE INCIDENT? check all that apply

- | | | |
|---|---|---|
| <input type="checkbox"/> Used equipment improperly | <input type="checkbox"/> Improper lifting/material handling | <input type="checkbox"/> Failure to keep worksite orderly |
| <input type="checkbox"/> Used wrong tool | <input type="checkbox"/> Running/Rushing/Acting in haste | <input type="checkbox"/> Improper/Inadequate PPE use |
| <input type="checkbox"/> Failure to warn about hazard | <input type="checkbox"/> Failure to disconnect power source | <input type="checkbox"/> Under influence of alcohol/drugs |
| <input type="checkbox"/> Horseplay/distractive action | <input type="checkbox"/> None | <input type="checkbox"/> Other (specify below): |

PREVENTATIVE MEASURES: (actions to prevent recurrence of incident) check all that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> Improve enforcement | <input type="checkbox"/> Repair/replace equipment | <input type="checkbox"/> Improve cleanup procedures |
| <input type="checkbox"/> Corrective counseling/re-education | <input type="checkbox"/> Adequate/Appropriate PPE | <input type="checkbox"/> Task Analysis/Procedure Revision |
| <input type="checkbox"/> Improve ventilation | <input type="checkbox"/> Eliminate worksite congestion | <input type="checkbox"/> Improve Lighting |
| <input type="checkbox"/> Other (specify): | | |

EMPLOYEE'S DESCRIPTION OF INCIDENT attach additional sheets if necessary

Employee Signature _____

Date _____

SUPERVISOR DESCRIPTION OF INCIDENT attach additional sheets if necessary

CORRECTIVE OR PREVENTATIVE MEASURES TAKEN

CORRECTIVE ACTION TAKEN	PERSON RESPONSIBLE	DATE COMPLETED

SUPERVISOR SIGNATURE _____ DATE _____

RISK MANAGER'S SIGNATURE _____ DATE _____