

# Accident Investigation Report

The unsafe acts of people, and the unsafe conditions that cause accidents, can be corrected only when they are known specifically. It is your responsibility 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.

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**PART I - General Information:** Agency Location Code \_\_\_\_\_ Dept/Area \_\_\_\_\_

Name of Injured \_\_\_\_\_ Social Sec. # \_\_\_\_\_

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## **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: \_\_\_\_\_

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Describe the Injury and body part(s) affected: \_\_\_\_\_

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

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Employee Signature: \_\_\_\_\_ Phone # \_\_\_\_\_ Date: \_\_\_\_\_

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

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**PART III – Supervisor’s Investigation of the Accident:** If you do not agree with the employees 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: \_\_\_\_\_

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**B.** Describe any UNSAFE Conditions : \_\_\_\_\_

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**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 ?)

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Has it been done ? \_\_\_\_\_ If not, give reason \_\_\_\_\_

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## 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

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

### Follow – up Action:

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