INCIDENT/ACCIDENT ANALYSIS FORM

Accident #

Employee Information:	Areas of Concern		Employee Injury Results
Employee Name:_____	Slips/Trips/Falls		Has the worker sought medical attention: Y / N Date:_____
Location:_____	Lifting / Overexertion		What parts of the body were injured:_____
Date of Injury:_____ Time:_____	Gate issues		_____
Date Reported to Supervisor:_____	Bloodborne Pathogen ex.		_____
Dept:_____	Restraint Issues		_____
Occupation of employee:_____	Chemical Exposures		**Claims Cost Control** - Have all parts of faulty equipment, machinery
	Car accidents / transport		or other evidence associated with this accident been preserved?
	Falling objects		_____YES _____NO - Explain_____
	Repetative Motion		_____
	Struck by Object		_____

Description

1. Describe the incident/accident. Include the machine, object or substance involved and explain exactly what the injured worker was doing._____

_____

_____

2. What did each co-worker or witness say about the incident/accident? (If necessary, attach additional sheets)._____

_____

_____

3. If pain gradually occurred, how does the employee relate the problem to work?_____

_____

4. Have other employees had injuries, accidents or near misses at or near this job site? If so, when, where and how are they related to this incident/accident?_____

_____

_____

5. If an unsafe act(s) was a cause of this incident/accident, why was the unsafe act committed?_____

_____

6. If an unsafe condition(s) was a cause of the incident/accident, why did the condition exist?_____

_____

7. If an organization cause(s) was a cause of the incident/accident, why did the cause exist?_____

_____

cc: Reviewing Manager

Safety Committee

Signature of person filling out the form:_____ Date:_____

Signature of Supervisor_____:_____ Date:_____