Accident investigation form (example 2)

Use this form to help you investigate workplace accidents or incidents. Note: this form is for use within your company. It is not intended to replace DCBS Form 801: *Worker's and Employer's Report of Occupational Injury or Disease*.)

Employee portion

Employee name: _____ Employee work phone: _____

Work unit: _____ Work section: _____

Supervisor name: _____ Supervisor work phone: _____

Length of service in present position: ☐ Less than 6 months ☐ 6 months-1 year ☐ 1-2 years ☐ 2-3 years 3-5 years ☐ More than 5 years

Exact location of accident/incident: _____

Accident/incident date: _____ Time: _____ ☐ a.m. ☐ p.m.

Witnesses Name: _____ Phone: _____

(☐ check if no witness) Name: _____ Phone: _____

Body part affected (check all that apply) ☐ Neck ☐ Shoulder(s) ☐ Elbow(s) ☐ Wrist(s)/hand(s) ☐ Thigh(s) ☐ Lower leg(s) ☐ Ankle(s)/foot(feet) ☐ Knee ☐ Hip ☐ Upper back ☐ Lower back ☐ Chest/abdomen ☐ Other: _____

Task that led to the incident: ☐ Driving ☐ Lifting ☐ Carrying ☐ Pushing/pulling ☐ Keyboarding ☐ Climbing ☐ Reaching ☐ Handling ☐ Bending ☐ Twisting ☐ Other:

Describe accident/incident in detail (use additional sheets if necessary):

Employee signature: Date:

Supervisor portion

Reported to: _____ Date: _____ Time: _____ ☐ a.m. ☐ p.m.

Supervisor's description of incident (what happened and why):

Corrective action:

Employee signature: Date: