EMPLOYEE ACCIDENT INVESTIGATION FORM

EMPLOYEE INFORMATION

Reset Form

Employee

Job Title | Date of Injury | Time of Injury

Department | Supervisor | Date HR was notified of Accident

	YES	NO
Was medical treatment provided?	☐	☐
Was employee transported to the hospital?	☐	☐
Was a drug test completed?	☐	☐

WITNESSES

Witnesses Name | Title | Phone Number

Witnesses Name | Title | Phone Number

Witnesses Name | Title | Phone Number

Describe the accident and/or injury

Contributing factors to accident

Lack of skill/abilities	☐
Physical weakness	☐
Carelessness	☐
Unsafe act	☐
Failure to use PPE	☐
Failure to follow procedure(s)	☐
Unsafe condition	☐
Distraction	☐
Fatigue	☐
Patient/other assault	☐
Other	☐

Describe

Describe any corrective actions taken or recommendations for policy changes or re-training

Supervisor's Signature _____ Date _____

Director's Signature _____ Date _____