



Incident Investigation Report Form

Instructions: Obtain statements from the injured employee and any witnesses to include what happened, what caused the incident and what were the contributing factors to the incident. To do this, reconstruct the sequence of events that led to the injury. Attach additional sheets if necessary. Provide copies of the completed form and all *Incident Statement Forms* to the following: Agency safety coordinator, the field safety coordinator, supervisor and bureau director or field manager.

Injured Employee Data		
Employee Name	Working Title	Personnel Number
Date of Incident	Time of Incident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Claim Number (if known)
Work Organization/Location		
Supervisor	Supervisor Phone	Supervisor Email

Incident Description:

- Where did the incident happen and who was involved? Provide a full description of the surroundings of the location and the individuals involved.
- What was happening at the time of the incident and why was it taking place?
- What events lead up to the incident? Describe the sequence in order and when they took place.
- What exactly caused the injury and how did it happen? What mechanics, equipment or tools were involved?
- Describe the injury. Include the affected body part(s) and injury type or indicate no injury occurred.
- If a physical injury was avoided, describe what happened that could have potentially resulted in injury?

Additional Information

Provide any additional information important to the investigation (pictures taken, evidence collected).

Initial Investigator:		
Incident Investigator Name	Date of Investigation	Time of Investigation <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.



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Supervisor's Form

Name of Injured Person: _____

What was the nature of the injury? Describe in detail. _____

Describe fully how the accident happened? _____

What caused the event? _____

Were safety regulations in place and used?
If not, what was wrong? _____

Recommended preventive action to take in the future to prevent reoccurrence. _____

Supervisor Signature Date: _____



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What CONDITION of tools, equipment, or work area contributed to incident?			<input type="checkbox"/> Not Applicable
<input type="checkbox"/> Close Clearance/Congestion	<input type="checkbox"/> Floors/Work Surfaces	<input type="checkbox"/> Poor Housekeeping	
<input type="checkbox"/> Hazardous Placement	<input type="checkbox"/> Inadequate Ventilation	<input type="checkbox"/> Equipment Failure	
<input type="checkbox"/> Inadequate Warning System	<input type="checkbox"/> Inadequate Illumination	<input type="checkbox"/> Hazardous Materials	
<input type="checkbox"/> Improper Material Storage	<input type="checkbox"/> Inadequate Guards/Barrier	<input type="checkbox"/> Defective Tools/Equipment/Vehicle	
<input type="checkbox"/> Inadequate/Improper PPE	<input type="checkbox"/> Equipment/Workstation Design	<input type="checkbox"/> Other _____	

What ACTION or INACTION contributed to the incident?			<input type="checkbox"/> Not Applicable
<input type="checkbox"/> Failure to Make Secure	<input type="checkbox"/> Used Defective Equipment	<input type="checkbox"/> Failure to Use PPE	
<input type="checkbox"/> Improper Lifting	<input type="checkbox"/> Improper Technique	<input type="checkbox"/> Improper Loading	
<input type="checkbox"/> Used Equipment Improperly	<input type="checkbox"/> Unauthorized Actions	<input type="checkbox"/> Operating at Improper Speed	
<input type="checkbox"/> Operating Procedure Deviation	<input type="checkbox"/> Improper Position	<input type="checkbox"/> Used Wrong Tool/Equipment	
<input type="checkbox"/> Horseplay/Distractive Active	<input type="checkbox"/> Unsafe Act of Another Staff	<input type="checkbox"/> Under Influence Drugs/Alcohol	
<input type="checkbox"/> Nullified Safety/Control Devices	<input type="checkbox"/> Running/Rushing/Acting in Haste	<input type="checkbox"/> Failure to Warn/Signal	
<input type="checkbox"/> Servicing Equipment in Motion	<input type="checkbox"/> Other _____		

CHECK ALL UNDERLYING OR ROOT CAUSES THAT APPLY

What caused or influenced the substandard conditions or behaviors?		
<input type="checkbox"/> Lack of Proper Procedures	<input type="checkbox"/> Inadequate Job Instructions	<input type="checkbox"/> Inadequate Tools
<input type="checkbox"/> Inadequate Job Training Methods	<input type="checkbox"/> Inadequate Supervision	<input type="checkbox"/> Improper Layout or Design
<input type="checkbox"/> Inadequate Maintenance Standards	<input type="checkbox"/> Unsafe Design or Construction	<input type="checkbox"/> Poor Work Practice
<input type="checkbox"/> Poor Work Design	<input type="checkbox"/> Inadequate Purchasing Standards	<input type="checkbox"/> Lack of Skill
<input type="checkbox"/> Lack of Communication Between Staff	<input type="checkbox"/> Improper Extension of Service Life	<input type="checkbox"/> Improper Planning
<input type="checkbox"/> Inadequate Cleaning	<input type="checkbox"/> Inadequate Environmental Controls	<input type="checkbox"/> Inadequate Capacity
<input type="checkbox"/> Inadequate Preventive Maintenance	<input type="checkbox"/> Inadequate Work Standards	<input type="checkbox"/> Other _____

CHECK ALL ACTIONS NECESSARY TO CORRECT THE DIRECT AND ROOT CAUSES

What corrective actions have been taken or are needed to prevent a recurrence?		
<input type="checkbox"/> Task Analysis/Procedure Revision	<input type="checkbox"/> Improve Clean-Up Procedures	<input type="checkbox"/> Repair/Replace Equipment
<input type="checkbox"/> Reinstruction of Employees	<input type="checkbox"/> Improve Storage/Arrangement	<input type="checkbox"/> Rotation of Employee
<input type="checkbox"/> Eliminate Congestion	<input type="checkbox"/> Improve/Change Work Method	<input type="checkbox"/> Identify/Improve PPE
<input type="checkbox"/> Task Analysis to Be Completed	<input type="checkbox"/> Install/Revise Guards/Devices	<input type="checkbox"/> Improve Enforcement
<input type="checkbox"/> Improve Design/Construction	<input type="checkbox"/> Job Reassignment of Employees	<input type="checkbox"/> Use Other Materials/Supplies
<input type="checkbox"/> Improve Illumination	<input type="checkbox"/> Mandatory Pre-Job Instructions	<input type="checkbox"/> Improve Ventilation
<input type="checkbox"/> Training in multiple areas		

Recommended corrective actions or preventive measures to be taken

Action Item	Person Responsible	Target Date	Date Complete

Investigation Review (Initial after reviewing the findings of the investigation):

	Initials	Review Date	Comments
Supervisor			
Manager			
Site/Regional Manager			
Safety Representative			
Director/Deputy			