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| **INCIDENT INVESTIGATION REPORT** | | | | |  |
| Every incident, whether serious or minor, is to be investigated. Root causes can be determined and corrected only after thorough investigation. Complete this report and submit it to Human Resources Department within 48 hours of the incident. Contact EOU Security for assistance completing this investigation report. | | | | |
| Employee Name: | | Location of Incident: | | | |
| Position: | | Date Incident Occurred: | | | |
| Department: | | Time of Incident: A.M. P.M. | | | |
| Site Location (if applicable): | | Date Reported to Supervisor: | | | |
| **DESCRIPTION OF INCIDENT** | | | | | |
| Describe what the incident was and how it occurred. Describe the materials, vehicles, equipment, buildings and people involved. If vehicle accident, provide explanation and diagram on reverse side. | | | | | |
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| **UNSAFE ACTS AND/OR HAZARDS INVOLVED IN THE INCIDENT** | | | | **DEFECTIVE EQUIPMENT** | |
| What unsafe acts or hazards contributed most directly to this incident? | | | | What equipment/tools caused this incident? | |
| [ ] Inadequate training or skills | [ ] Horseplay | | | [ ] Defective equipment or tools | |
| [ ] Not following training or rules | [ ] Operating without authority | | | [ ] Poor ventilation | |
| [ ] Incorrect instruction or training | [ ] Inadequate physical capability | | | [ ] Improper machine guarding | |
| [ ] Using improper work methods | [ ] Failure to secure equipment | | | [ ] Improper equipment maintenance | |
| [ ] Improper protective equipment | [ ] Unsafe equipment/tools | | | [ ] Faulty safety device | |
| [ ] Other: (describe on reverse) | | | | [ ] Other: (describe on reverse) | |
| **List witnesses to the incident here and have witnesses complete the witness form:** | | | | | |
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| **ROOT CAUSE(S) OF INCIDENT:** Describe the most important underlying cause(s) of the incident | | | | | |
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| **IF INJURY OR ILLNESS HAS OCCURRED:** [ ] No Injury or Illness Has Occurred | | | | | |
| Part of body injured: | | | Do you question validity of claim? [ ] Yes [ ] No | | |
| Describe the Illness/Injury: | | | | | |
| Treatment received (check all that apply): [ ] Clinic [ ] E.R./Ambulance [ ] On-site 1st Aid [ ] 1st Aid Declined  *Note: A medical “801 form” claim must be promptly completed by the employee when treatment from a medical provider (clinic, EMT, hospital, etc.) was obtained. The completed 801 claim form is to be submitted to the Human Resources Dept.* | | | | | |
| **RECOMMENDATIONS: What action(s) should be taken to prevent this type of incident from happening again?** | | | | | |
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| **Investigator *Signature*: Title: Date:** | | | | | |

**INCIDENT INVESTIGATION REPORT (continued)**

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| **UNSAFE ACTS AND/OR HAZARDS:** |
| Please provide details if **"Other"** was checked under this section. |
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| **DEFECTIVE EQUIPMENT** |
| Please provide details if **"Other"** was checked under this section. |
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| **EMPLOYEE OR OTHER Witness**  **Account of Incident** | |  | |
| This form is for the employee or a witness to complete about a work-related incident. It should be completed and submitted to the Human Resources Department within 48 hours of the incident. | |
| **Employee or Witness Name:** | **Date Incident Witnessed:** | | |
| **Position/Title:** | **Time Incident Witnessed:** | | |
| **Department:** | **Location of Incident:** | | |
| **DESCRIPTION OF INCIDENT** | | | |
| * As best you can, please describe in detail what the incident was and how it happened. * Describe the materials, vehicles, equipment, buildings and people involved. * Describe the type of illness or injury (cut, strain, etc.) and any body part(s) injured. | | |
|  | | | |
| The above information is true and correct to the best of my knowledge. | | |
| **Employee or Other Witness *Signature*: Date:** | | |