emc INSURANCE

Keeping insurance human®

Accident investigation report

Use this form to document the investigation of an accident, injury, or near-miss incident.

Accident information

Name(s) of injured employee(s): _____ Date of accident/injury/illness: _____

Work area of injured employee(s): _____ Date investigation began: _____

Describe nature of accident, injury, or illness:

_____

_____

_____

_____

_____

_____

_____

_____

Part(s) of body affected: _____

Describe medical treatment administered:

_____

_____

_____

_____

Witness information

Witness #1 name: _____ Phone: _____

Witness's description of accident/incident:

_____

_____

_____

_____

Witness's signature: _____

Witness #2 name: _____ Phone: _____

Witness's description of accident/incident:

_____

_____

_____

_____

Witness's signature: _____

Reset form

Investigation results

List contributing factors/root causes:

_____

_____

_____

_____

_____

Was a mandatory safe work practice violated? ..... Yes ☐ No ☐

Was the unsafe condition, practice, or protective equipment problem corrected immediately? .... Yes ☐ No ☐

If no, what has been done to ensure correction?:

_____

_____

_____

_____

_____

Do additional mandatory safe work practices need to be implemented?..... Yes ☐ No ☐

If yes, please describe safe work practice:

_____

_____

_____

_____

_____

List corrective actions taken and date implemented:

_____

_____

_____

_____

_____

Signature of investigator:_____ Date: _____

Signature of person responsible for corrective actions: _____ Date: _____

Reset form