ACCIDENT INVESTIGATION FORM

Name of Injured Person: ________________________________ Date of Injury: _____________

Name of Supervisor: _______________________________ Telephone #: __________________

Department: _________________________ Location of Injury: __________________________

Brief Description of Accident:

Nature of Injury (describe all body parts affected):

Was Training Provided?	Yes	☐	No	☐	NA	☐
Were established procedures followed?	Yes	☐	No	☐	NA	☐
Were tools or equipment adequate for task?	Yes	☐	No	☐	NA	☐
Were environmental conditions a factor in the incident?	Yes	☐	No	☐	NA	☐

Elaborate on Responses:

Proposed Corrective Action:

Supervisor: _______________________________ Date of Report: ________________

Signature: ____

IIPP-Appendix D
March 2006

Completed copies of this form should be routed to the department Safety Coordinator and kept in department files for at least three years.