**Incident Investigation Report**

The purpose of this report is to help prevent similar incidents from recurring. Make this report as accurate and thorough as possible. Remember, always follow-up with the appropriate corrective action(s).

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| --- | --- | --- | --- | --- | --- |
| Incident: | 🞎 Near Miss | 🞎 Minor Injury | 🞎 Minor Illness | 🞎 Major Injury | 🞎 Major Illness |

Incident Date: Time: AM/PM

Injured Employee:

Occupation: Months on this job:

|  |  |
| --- | --- |
| **Incident Description** |  |
| Where did the incident occur?   |

|  |
| --- |
| Circle Affected Body Part |

 |
| Witness(es)   |
| How did the incident occur? (What was the employee doing when injured?)   |
| Describe the injury(s) or damage   |
| What unsafe act(s) or condition(s) contributed to the incident?    |
| **Corrective Actions** |  |
| What do you recommend be done (or have you done) to prevent this type of incident from recurring?   |
| What corrective action(s) has (have) been taken? Date:    |

Investigation conducted by: Date:

Report reviewed by: Date:

**Employee Report of Injury**

The purpose of this report is to prevent similar incidents from occurring. It should be completed and signed by the injured worker.

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| --- | --- | --- | --- | --- | --- |
| Incident: | 🞎 Near Miss | 🞎 Minor Injury | 🞎 Minor Illness | 🞎 Major Injury | 🞎 Major Illness |

Incident Date: Time: AM/PM

Injured Employee:

Occupation: Months on this job:

|  |  |
| --- | --- |
| **Incident Description** |  |
| When did you report the incident and to who?   Did you require medical attention? Yes: No: Location of incident (entrance, loading dock, bathroom, etc.)   |

|  |
| --- |
| Circle Affected Body Part |

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| Witness(es)   |
| Describe in detail how the incident occurred and what you were doing when it occurred?   |
| What body part(s) were affected?    |
| What unsafe act(s) or condition(s) contributed to the incident?    |
| What is at least one thing that can be done to prevent this type of incident from recurring?   |

Employee Signature: Date:

**Witness Incident Report**

The purpose of this report is to prevent similar incidents from occurring. Remember, we are fact finding, not fault finding. Please make this report as accurate and thorough as possible.

Witness Name: Time: AM/PM

Job Title/Occupation: Work Phone:

Incident Date: Time: AM/PM

Injured Employee:

|  |
| --- |
| **Incident Description** |
| Location of incident (entrance, loading dock, bathroom, etc.)   |
| Describe in detail what you observed; how the incident occurred, what injury occurred, and what the employee was doing when it occurred.       Did you see any unsafe act(s) or condition(s) that contributed to the incident?   Do you believe this could have been prevented?   |

Witness Signature: Date: