ACCIDENT INVESTIGATION REPORT

EMPLOYEE NAME: _____ **DATE:** _____
(Please Print) Last First

SOCIAL SECURITY NUMBER: _____ **JOB TITLE:** _____

Place of accident/injury (specifically building, floor, patient room):	Was this employee's assigned work area? □ Yes □ No
Date reported to management: By whom:	Reported at: : am/pm

CAUSE OF ACCIDENT/INJURY

Check the appropriate box(s) in each category.

UNSAFE ACTS/CONDITIONS	CONTRIBUTING FACTORS	PERSONAL FACTORS
□ Using broken equipment □ Improper labeling □ Adjusting or cleaning equipment □ Unnecessary haste / excess speed □ Improper lifting equipment □ Failure to use protective equipment □ Violation of safety guidelines □ Did not follow instructions □ Victim of assault □ Motor vehicle accident □ Other:	□ Safety guards missing □ Use of improper tool / equipment for job □ Using equipment without training □ Unsafe storage equipment / supplies □ Congestion □ Malfunctioning ventilation system □ Insufficient lighting □ Safety equipment not available □ Poor housekeeping □ Other:	□ Untrained for assigned duty □ Tired or fatigued □ Physical impairment □ Emotional factors □ Inattention to tasks being performed □ Improper dress / attire □ Individual was distracted □ Employee was overly aggressive □ Other:

Check the appropriate box(s) that best describes the injury.

TYPE OF INJURY

□ Abrasion □ Contusion □ Infectious Exposure □ Punctured Wound □ Toxic Exposure

□ Burn □ Fracture □ Laceration □ Strain / Sprain

□ Other (please specify): _____

PART OF BODY

□ Arm □ Face □ Foot □ Head □ Upper Back □ Lower Back

□ Eye □ Finger □ Other: _____

□ Right Side □ Left Side

CORRECTIVE ACTION(S)

Retraining □	Verbal Warning □	Written Warning □	Maintenance Work Order □	Other □
Responsible Person(s):				
Target Completion Date:				