

INCIDENT INVESTIGATION REPORT FORM

Employee Name: _____ Dept: _____

Date & Time Incident Reported: ____ / ____ / ____ @ ____ : ____ AM / PM
MM DD YY

Date & Time Incident Occurred: ____ / ____ / ____ @ ____ : ____ AM / PM
MM DD YY

Location of Incident: _____

Vehicle Involved: No Yes _____
Vehicle ID Number Date of Last Vehicle Inspection

Police Report: No Yes # _____

Photos: No Yes **Name of HR Representative Notified:** _____

Supervisor's Report of Incident

Describe in Detail What Happened: _____

Why Did the Incident Occur? _____

Nature of Injury, Injury Type and Part of Body Affected: _____

Contributing Factors:

- Environmental (Noise, Vapors, Light, Heat, Critters, etc...)
- Design (Workplace Layout, Design of Tools and Equipment)
- System & Procedures (Lack of or Inappropriate Systems and Procedures)
- Human Behavior

Comments: _____

How was the employee trained for performing this job task? _____

What is the safety procedure for this job? _____

What will be done in the interim and in the future to prevent this type of Incident? _____

Please check below what is applicable:

- I have reviewed the employee's statement and interviewed witnesses listed in the employee's report.
- I have discussed this completed report with the employee before turning it into Human Resources and the Department Director. Date: _____
- I have informed the employee that this incident may be reviewed by the Accident Review Committee.

Reporting Supervisor's Signature

Date

Department Director's Signature

Date

Employee's Report of Incident

The purpose of this report is to help us prevent future accidents/incidents from occurring and may be used by the Accident Review Committee.

Date & Time Incident Occurred: ____ / ____ / ____ @ ____ : ____ AM / PM
MM DD YY

Who else was with you or witnessed the incident when it occurred? _____

What were you doing at the time the incident occurred? _____

What happened? _____

How do you think the incident occurred? _____

Nature of Injury, Injury Type and Part of Body Affected: _____

How were you trained for performing this job task? _____

What is the safety procedure for this job? _____

What Personal Protective Equipment (PPE) were you wearing at the time of the accident/incident? _____

- I did/will seek medical treatment for this accident/incident.
- I did not/will not seek medical treatment for this accident/incident *at this time*. If I decide to seek treatment at a later date for this accident/incident, I understand that I need to call 1-855-364-8567 for authorization.

I understand that if I have sustained an injury/illness due to this accident/incident, I am required to report it immediately to my supervisor so that I can be treated at a facility authorized by the City's Workers' Compensation insurance. I further understand that I am responsible for reporting injuries/illnesses to Workers' Compensation by calling 1-855-364-8567.

Employee's Signature

Date

Employee's Printed Name: _____

