



INCIDENT INVESTIGATION FORM

Type of Incident: (choose one) _____

Today's Date: _____ Date Reported: _____

Initial Treatment: (choose one) _____

Days Away From Work (#) Restricted Work Days (#)

Name of Individual Involved: _____ Category: (choose one) _____

Date of Incident: _____ Time of Incident: _____ Phase of the Day: _____

Specific Location of Incident: _____

Employee's Occupation or N/A for Student/Visitor/Guest: _____

Task at Time of Incident: _____

Time Worked Prior to Incident (that day) or N/A for Student/Visitor/Guest: _____

Length of Service in this Job or N/A for Student/Visitor/Guest: _____

Was Individual Alone at Time of Incident? Yes No

If not, who was the Witness(es)? _____

Supervisor's/Instructor's/Reporter's Name: _____

Part of Body Injured or Affected: (check all that apply)

- | | | | | | |
|---------------------------------------|---------------------------------|----------------------------------|-----------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Skull, Scalp | <input type="checkbox"/> Jaw | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Forearm | <input type="checkbox"/> Eye | <input type="checkbox"/> Neck | <input type="checkbox"/> Back | <input type="checkbox"/> Hand | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Toe | <input type="checkbox"/> Nose | <input type="checkbox"/> Spine | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Elbow |
| <input type="checkbox"/> Lower Leg | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle | <input type="checkbox"/> Mouth | <input type="checkbox"/> Chest | <input type="checkbox"/> Foot |

Nature of Injury or Illness: (check all that apply)

- | | | | | | |
|--|-----------------------------------|---|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Bruise, Contusion | <input type="checkbox"/> Puncture | <input type="checkbox"/> Cumulative Trauma | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Abrasion | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Heat/Cold Stress | <input type="checkbox"/> Burn | <input type="checkbox"/> Insect/Animal Bite | <input type="checkbox"/> Chemical Expos. | <input type="checkbox"/> Irritation | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Fracture | <input type="checkbox"/> Muscle Sprain | <input type="checkbox"/> Laceration | <input type="checkbox"/> Amputation | <input type="checkbox"/> Dislocation |
| <input type="checkbox"/> Foreign Body | <input type="checkbox"/> Respir. | | | | |

What Condition of Tools, Equipment, or Work Area Contributed to the Incident: (check all that apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Close Clearance/Congestion | <input type="checkbox"/> Floors/Work Surfaces | <input type="checkbox"/> Inadequate Housekeeping | <input type="checkbox"/> Illumination |
| <input type="checkbox"/> Defective Tools/Equipment/Vehicle | <input type="checkbox"/> Equipment Failure | <input type="checkbox"/> Inadequate Ventilation | <input type="checkbox"/> Haz. Placement |
| <input type="checkbox"/> Inadequate Warning System | <input type="checkbox"/> Equip./Workstation Design | <input type="checkbox"/> Inadequate Guards/Barrier | <input type="checkbox"/> Improper PPE |
| <input type="checkbox"/> Not Applicable | | | |

