



*County of Marin*  
**Employee Accident/Injury/Illness  
Investigation Report Form**

Risk Management Division, County Administrator's Office  
*PMR 42 – Benefits*

---

**EMPLOYEE ACCIDENT/INJURY/ILLNESS INVESTIGATION REPORT**

Employee name: \_\_\_\_\_ Department: \_\_\_\_\_

Date of accident/injury/illness: \_\_\_\_\_

Person(s) conducting investigation (include title): \_\_\_\_\_  
\_\_\_\_\_

Witnesses (If none, so state): \_\_\_\_\_  
\_\_\_\_\_ (Attach witnesses' statements).

Describe workplace condition, employee work practice or equipment which caused the accident/injury/illness [NOTE: Preserve faulty equipment as evidence so that the County may seek reimbursement from a responsible third party]: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe recommended actions to prevent reoccurrence: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is action plan required to correct hazard: \_\_\_\_ Yes \_\_\_\_ No

If Yes, date plan submitted to Program Administrator(s): \_\_\_\_\_

Until corrected, describe actions taken to protect employees in the interim: \_\_\_\_\_  
\_\_\_\_\_

Person responsible for corrective action: \_\_\_\_\_

Title: \_\_\_\_\_ Date correction completed: \_\_\_\_\_

Signature of person responsible for corrective action: \_\_\_\_\_

Signature of Supervisor: \_\_\_\_\_