Employee Accident/Injury/Illness Investigation Report Form

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: ______________________________

Effective Date: January 2005