

INCIDENT INVESTIGATION REPORT



Making workers' comp work

1. Injured Employee Information

Name _____

Job Title _____

Incident Date _____

2. Time of Incident

AM

PM

3. Was the incident during the employee's normal work schedule?

Yes No Overtime

4. Day of Week

Mon Tues Wed

Thurs Fri Sat Sun

5. Location

Please describe the location where the incident occurred:

6. Did incident occur on employers' premises?

Yes No

7. Action Taken by Company

In Plant First Aid

Medical Treatment

Lost Work Day

8. Provide an explanation of the incident. (Be specific)

9. Part of Body Affected

Head Chest

Eye Lungs

Ear Abdomen

Neck Groin

Shoulder Hips

Arm Knee

Elbow Leg

Wrist Ankle

Hand Foot

Finger Toes

Back Other

10. Type of Incident

Overexertion

Fall - Different Level

Fall - Same Level

Struck Against

Caught Between

Struck By

Vehicle

Electrical

Extreme Temps

Repetitive Motion

Radiation

Absorption

Slip (no fall) Twist

Other _____

11. Did the employee report any of the following?

- Back Strain
- Sprain
- Dislocation
- Fracture
- Contusion
- Amputation
- Open Wound
- Burn
- Asphyxia
- Hearing Loss
- Foreign Body
- Multiple Injury
- Cumulative Trauma

Other _____

12. After printing, use this area to illustrate the incident. (if applicable)

13. Personal Protective Equipment (PPE) in use at the time of the incident.

14. Note any additional information or recommendations.

Employee _____

(Signature)

Date ___ / ___ / ____

Completed by: _____

(Signature)

Title _____

Date ___ / ___ / ____