

## Employee Injury Accident Investigation Report

<b>Employee Name:</b> _____	<b>Date of Accident:</b> _____
<b>Occupation:</b> _____	<b>Time of Accident:</b> _____
<b>Location:</b> _____	<b>Date of Report:</b> _____
	<b>Prepared By:</b> _____

Unsafe Condition	Unsafe Act
<input type="checkbox"/> Improper Machine Guarding <input type="checkbox"/> Defective Tool <input type="checkbox"/> Slip, Trip or Fall Hazard <input type="checkbox"/> Inadequate Lighting <input type="checkbox"/> Improper Ventilation <input type="checkbox"/> Poor Material Storage <input type="checkbox"/> Gases, Fumes, Vapors <input type="checkbox"/> Fire Hazard <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/> Operating Without Authority <input type="checkbox"/> Bypassed Safety Device <input type="checkbox"/> Improper Lifting <input type="checkbox"/> Lack of Personal Protective Equipment <input type="checkbox"/> Using Defective Tools or Equipment <input type="checkbox"/> Improper Use of Tools <input type="checkbox"/> Failure to Lock Out Equipment <input type="checkbox"/> Failure to Properly Secure Materials <input type="checkbox"/> Taking Unsafe Position <input type="checkbox"/> Other: _____ _____

Nature of Injury	Part of Body
<input type="checkbox"/> Cut <input type="checkbox"/> Puncture <input type="checkbox"/> Abrasion <input type="checkbox"/> Amputation <input type="checkbox"/> Bruise <input type="checkbox"/> Strain <input type="checkbox"/> Sprain <input type="checkbox"/> Chemical Burn <input type="checkbox"/> Burn Other <input type="checkbox"/> Fracture <input type="checkbox"/> Foreign Object <input type="checkbox"/> Inhalation <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Other: _____	<input type="checkbox"/> Skull <input type="checkbox"/> Face <input type="checkbox"/> Eye <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Hand <input type="checkbox"/> Finger <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Back <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Calf <input type="checkbox"/> Foot <input type="checkbox"/> Ankle <input type="checkbox"/> Toe <input type="checkbox"/> Abdomen <input type="checkbox"/> Eye <input type="checkbox"/> Nose <input type="checkbox"/> Other: _____

<b>Type of Injury:</b>	<input type="checkbox"/> First Aid	<input type="checkbox"/> Doctors Case	<input type="checkbox"/> Fatality
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**Describe How The Accident Occurred:** \_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

**Corrective Action Taken:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Note:** This is a company form to be completed by the supervisor and does not replace any OSHA form, any state first report of injury form or any insurance claim form.