



**ACCIDENT/INCIDENT REPORT
(Including Illness or Near Misses)**

Investigation Report

Date of accident or illness:		Time of day:	
Date reported:		Location:	
Person involved:	<input type="checkbox"/> Employee	<input type="checkbox"/> Temporary	
	<input type="checkbox"/> Contractor	<input type="checkbox"/> Visitor	
Position title:		Date employed:	
Department:		Manager or supervisor:	
Witness #1:		Witness #2:	
Description of the injury or illness:			
Description of activity at the time of the accident:			
Accident resulted in:	<input type="checkbox"/> Injury	<input type="checkbox"/> Lost time	<input type="checkbox"/> Medical clinic treatment
<input type="checkbox"/> Property damage	<input type="checkbox"/> Illness	<input type="checkbox"/> First aid	<input type="checkbox"/> Near Miss
Recommended corrective action:		By Whom	By When
Immediate corrective action taken:		By Whom	By When
Investigated by:			
Title:		Date:	



Supervisor's Report				
Employer:		Injured employee:		
Location:		Treating Doctor:		
Occupation of injured employee:			Age of injured employee:	
Date of injury:		Time of injury:		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Nature of injury (such as strain, cut, or bruise):				
Part of body that was injured (such as left hand or right ankle):				
Did injured employee return to work?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Time:				
Where and how did the accident happen? 3				
Specify any equipment, substance, or object connected with the accident or illness:				
What was the employee doing at the time of the accident or illness?				
Witness/es:				
Measures recommended to prevent a similar accident:				
Supervisor signature:				Date:



Employee's Report			
Employer:		Employee:	
Location:		Treating Doctor:	
Occupation:			Age:
Date of injury:		Time:	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Nature of injury (such as strain, cut, or bruise):			
Part of body that was injured (such as left hand or right ankle):			
Did you return to work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____ Time: _____
Where and how did the accident happen?			
Specify any equipment, substance, or object connected with the accident or illness:			
What were you doing at the time of the accident or illness?			
Witness/es:			
Do you have any recommendations to prevent a similar accident:			
Employee signature:			Date: