

## Accident / Investigation Form

Last Name:	First Name	Occupation/Job Title	Yrs. Experience in Occupation
Full Address:			
City/Town			Postal Code
Division/Branch		Date of Occurrence	Time
Location		Date Reported	Time
<input type="checkbox"/> Hazardous Situation <input type="checkbox"/> Incident <input type="checkbox"/> First Aid <input type="checkbox"/> Health Care <input type="checkbox"/> Lost Time <input type="checkbox"/> Critical Injury			
Describe what happened and, if applicable, describe injury. Attach additional pages and an accident/incident diagram, if appropriate.			
Describe the nature, date and time of first aid treatment, if applicable.			
<b>Part of Body Injured</b> (Indicate "R", "L", or "B", where applicable)			Signature of person reporting incident
<input type="checkbox"/> Head	<input type="checkbox"/> Lower back	<input type="checkbox"/> Hand/fingers	<input type="checkbox"/> Ankle/foot
<input type="checkbox"/> Eye	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Hip	<input type="checkbox"/> Other
<input type="checkbox"/> Neck	<input type="checkbox"/> Elbow	<input type="checkbox"/> Upper leg	
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Lower Arm	<input type="checkbox"/> Knee	
<input type="checkbox"/> Upper back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Lower leg	
<b>Type of Accident/Incident</b>			
<b>Check off (✓) statements that best describe the accident/incident:</b>			
<input type="checkbox"/> Repetitive Strain	<input type="checkbox"/> Slip/fall	<input type="checkbox"/> Exposure to	
<input type="checkbox"/> Acute Strain (lifting, pulling, carrying)	<input type="checkbox"/> Vehicle	<input type="checkbox"/> Other (explain)	
<input type="checkbox"/> Caught in/under/between	<input type="checkbox"/> Client/employee action		
<input type="checkbox"/> Struck, contacted by/with/against	<input type="checkbox"/> Cut/bruise		
<b>Witnesses</b>			
Name			Telephone
Address			
Name			Telephone
Address			
Physician's Name			Telephone
Address			
Remember to attach witness(es) statement(s) on the Witness Statement form.			

**Causes: Check (✓) all that are applicable**

**Conditions**

- Congestion or restricted action
- Poor housekeeping; disorderly workplace
- Slip/trip hazards
- Lack of inappropriate furniture/equipment
- Design or arrangement of furniture/equipment
- Defective furniture, tools, equipment or materials
- Inadequate or excessive illumination
- Inadequate ventilation
- Excessive noise
- Inadequate or improper protective equipment
- Fire and explosion hazards
- Inadequate warning systems
- Irrate client/employee action
- Adverse weather
- Other (explain):

**Practices**

- Improper body position/posture
- Tasks not varied/micro breaks not taken
- Unnecessary rushing
- Improper lifting
- Unsafe loading/placement
- Using defective equipment
- Using equipment improperly
- Altering or modifying equipment
- Not using personal protective equipment or failing to use it properly
- Not following appropriate procedures
- Inappropriate conduct
- Hazardous personal attire
- Other (explain):

What are the reasons for the existence of these practices and/or conditions?

**Prevention/Corrective Action**

Actions to prevent accident/incident recurrence. Check (✓) those actions taken to prevent recurrence. Mark with (P) other corrective actions decided upon or planned but not yet carried out. More than one item may apply.

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|--|--|
| <input type="checkbox"/> Training/instruction of person involved                       | <input type="checkbox"/> Request ergonomic assessment                              |
| <input type="checkbox"/> Improve work procedures                                       | <input type="checkbox"/> Request environmental assessment                          |
| <input type="checkbox"/> Inform staff/managers of safe work procedures                 | <input type="checkbox"/> Correction of work area                                   |
| <input type="checkbox"/> Perform job safety analysis                                   | <input type="checkbox"/> Recommend development/improvement to training/OHS program |
| <input type="checkbox"/> Inform staff/managers of hazard and how to protect themselves | <input type="checkbox"/> Reassess work standards                                   |
| <input type="checkbox"/> Notify appropriate individuals                                | <input type="checkbox"/> Reassignment of person                                    |
| <input type="checkbox"/> Improve engineering/design                                    | <input type="checkbox"/> Improve housekeeping                                      |
| <input type="checkbox"/> Improve inspection procedures                                 | <input type="checkbox"/> Other (describe):   |
| <input type="checkbox"/> Tools, equipment, furniture repair or replacement             |  |

Remember that ALL corrective action must be documented on the Corrective Action form.

Describe actions taken.

**Investigated by:**

Signature	Name (print)	Date (dd-mmm-yyyy)
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**Review by:**

Signature	Name (print)	Date (dd-mmm-yyyy)
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