Incident Type:
- ☐ Injury
- ☐ Near Miss
- ☐ Environmental Release
- ☐ Safety Concern
- ☐ Property Damage
- ☐ First Aid

INCIDENT INVESTIGATION REPORT

FR-001

EMPLOYEE INFORMATION

Employee Name: _____ (First) _____ (M.I.) _____ (Last)

Employee Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

Employee Home Phone: _____ Employee ID#: _____

OCCUPATION INFORMATION

Department: _____ Shift Being Worked: _____

Occupation: _____ (At time of incident) Experience at Position (months or years): _____

Occupation: _____ (Normal occupation) Experience at Position (months or years): _____

REPORTING INFORMATION

Location of Incident _____

Date of Incident: _____ Time of Incident _____ ☐ AM or ☐ PM

Date reported: _____ Time Reported: _____ ☐ AM or ☐ PM

To Whom Reported: _____

MEDICAL INFORMATION

Did the employee seek immediate Medical Treatment: ☐ Yes ☐ No

If "YES" Date of Treatment: _____ Treatment Facility Name: _____

Lost Time ☐ Y or ☐ N Days Away: _____ Restrictive Work Duty: _____

Drug / Alchol Screen ☐ Y ☐ N

ACCIDENT CLASSIFICATION

Incident Type (Check One):

- ☐ Caught (In, On, or Between)
- ☐ Contact Chemical(s), Biological Agent
- ☐ Electric Current
- ☐ Exposure to Radiation
- ☐ Foreign Matter
- ☐ Fire, Explosion
- ☐ Hot/Cold Objects, Temperature
- ☐ Inhalation, Absorption, Ingestion
- ☐ Lifting, Lowering
- ☐ Pushing, Pulling
- ☐ Repetitive Operations
- ☐ Bend/Twist
- ☐ Rubbed Or Abraded
- ☐ Rough or Sharp Surfaces
- ☐ Motor Vehicle Accident
- ☐ Other, Explain: _____
- ☐ Fall
- ☐ Slip, Trip
- ☐ Step On/In
- ☐ Struck Against
- ☐ Struck By Falling Object
- ☐ Struck By Flying Object
- ☐ Sports, Type: _____

Body Part or System: Identify R (Right) or L (Left) if Applicable

Rt. ☐ Lf. ☐

- ☐ Finger
- ☐ Hand
- ☐ Other: _____
- ☐ Wrist
- ☐ Arm
- ☐ Face
- ☐ Trunk
- ☐ Back
- ☐ Neck
- ☐ Eyes
- ☐ Foot
- ☐ Leg
- ☐ Head

Injury / Illness (check all that apply)

- ☐ Abrasion
- ☐ Laceration
- ☐ Puncture Wound
- ☐ Dislocation
- ☐ Avulsion
- ☐ Amputation
- ☐ Contusion/Bruise
- ☐ Sprain/Strain
- ☐ Repetitive Trauma
- ☐ Crush
- ☐ Contusion
- ☐ Fracture
- ☐ Hernia
- ☐ Internal Injury
- ☐ Burn (Chemical/Thermal)
- ☐ Electric Shock
- ☐ Conjunctivitis
- ☐ Hearing Loss(Sudden)
- ☐ Hearing Loss(Gradual)
- ☐ Multiple Injury
- ☐ Other(Describe): _____
- ☐ Irritation
- ☐ Dust Disease
- ☐ Heat Stress
- ☐ Physical Agent Disorder
- ☐ Skin Disorder
- ☐ Poisoning

WORK ELEMENT (CHECK ALL THAT APPLY)

- ☐ TASK ENVIRONMENT: Maintained/orderly, Job design/layout, Walking/Work surfaces, Physical demands, Work area conditions (i.e. noise/lighting)
- ☐ EQUIPMENT: Selection/Application, Maintenance, Equipment design, Placement
- ☐ BEHAVIORS: Written procedures, Unwritten procedures, Communications, Mental demands
- ☐ OTHER(EXPLAIN): _____

WITNESS CONTACT INFORMATION

SUPERVISOR STATEMENT

Supervisor's Name: _____

Supervisor's Signature: _____ Date: _____

CORRECTIVE ACTION

Corrective Action	Person Responsible	Estimated Completion Date	Actual Completion Date

REVIEW APPROVAL

Supervisor: _____ Date: _____

Department Manager: _____ Date: _____

Attach Employee Written Statement With all Other Supporting Documentation

MVA INVESTIGATION REPORT

FR-001-MVA

Complete this section if involved in a motor vehicle accident

EMPLOYEE INFORMATION

Employee Name: _____ (First) _____ (M.I.) _____ (Last)

_____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

Unit #: _____ Supervisor: _____

Number of Vehicles Involved: _____

SECONDARY VEHICLE

Drivers Name: _____ (First) _____ (M.I.) _____ (Last)

Tag #: _____ _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

Make & Model: _____ Year: _____

ACCIDENT LOCATION

Location of Accident: _____

Date of Accident: _____ Time of Accident: _____ ☐ AM or ☐ PM

Date reported: _____ Time Reported: _____ ☐ AM or ☐ PM

To Whom Reported: _____

WEATHER CONDITIONS

☐ Clear ☐ Ice ☐ Snow ☐ Rain

☐ Cloudy ☐ Overcast ☐ Sunny ☐ Other

ACCIDENT CLASSIFICATION

Roadway/Location

ROADWAY:

☐ Straight ☐ Hill ☐ Dry ☐ Snow/Ice

☐ Level ☐ Curved ☐ Muddy ☐ Wet

LOCATION:

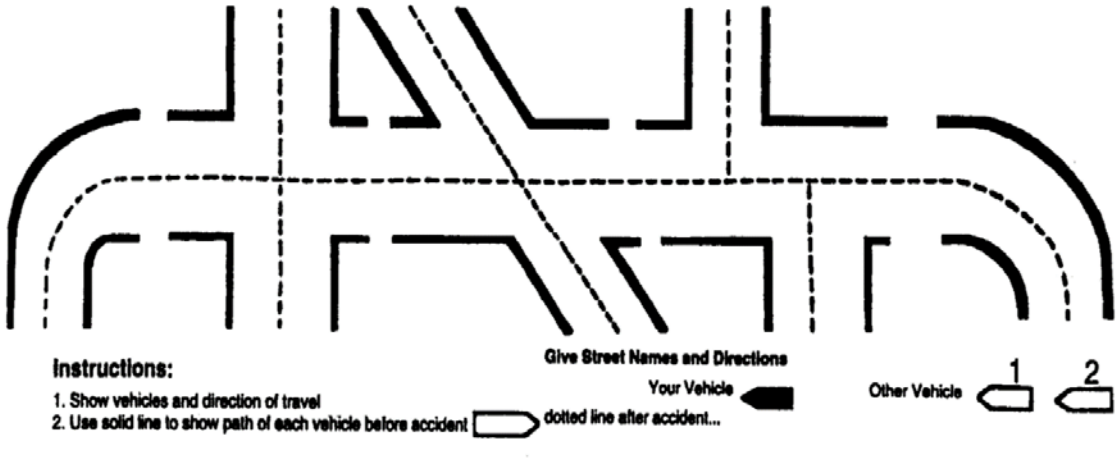
☐ In Yard ☐ Median/Right of Way ☐ Parking Lot ☐ Traveling To/From

Type of Loss

☐ Property Damage ☐ Vehicle Damage

CONTINUE ON NEXT PAGE FOR DIAGRAM AND STATEMENTS

ACCIDENT DIAGRAM



DESCRIPTION OF ACCIDENT

WITNESS STATEMENTS

REVIEW APPROVAL

Supervisor: _____ Date: _____

Department Manager: _____ Date: _____