|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ACCIDENT/INJURY/ILLNESS INVESTIGATION REPORT **(FORM TO BE USED TO DOCUMENT NEAR MISSES ALSO)** | | | | | | |
| **Employee Name:**       **Date of Injury/Illness:   /  /**  **Social Security #:**       **Department:** | | | | | | |
| **Employee Required:  First-Aid Only  Medical Treatment  Fatality   /  /     (date of death)  OSHA Recordable** | | | | | | |
| Completed Industrial Commission Form 19 and forwarded copies to Human Resource Services and Office of Safety? | | | Attached “Attending Physician Form” from Student Health Service? | | | |
| Went to Gove Student Health Center? If not why? | | | Will follow-up or referral treatment be needed? If so, where? | | | |
| Injury/Illness caused employee to miss work or to have restricted duties? | | | Date employee is expected to return to work   /  /  Date employee is to be off restricted work   /  / | | | |
| **Location of Accident (specify site):** | | | | | | |
| **Witnesses Name:** | | | | **Telephone Number: (**   **)**    **-** | | |
| **PROPERTY DAMAGE  Does not apply  Major  Serious  Minor [** **] Vehicle [** **] Equipment [** **] Private Property** | | | | | | |
| **Vehicle I.D:.**  **Model:       Model:** **Age:** **(yrs)**  **Driver’s License #:** **Exp:   /  /** | | | **Equipment I.D.:**  **Model:** **Type:       Age:** **(yrs)** | | | |
| **Employee Description of Accident/Incident (to be completed by injured/ill employee):**  **Describe injury/illness:**  **How did it happen?**  **(use separate sheet, if additional space is needed)** Employee’s Signature: Telephone: (   )    -     Date:  /  / | | | | | | |
| Name & Title of person most directly responsible for employee involved in accident (Supervisor):Name: Title:       Telephone: (   )    -     Date:  /  / | | | | | | |
| **IMMEDIATE CAUSE(s)**  Equipment  Personnel  Environment  Mgt.  Hazardous Conditions  Unsafe Act | | Explain: | | | | |
| **BASIC CAUSE & CONTRIBUTING FACTOR(s)**  Environmental conditions  Personnel  Hazardous conditions  Management  Lack of safety instruction & training | | Explain: | | | | |
| **CORRECTIVE ACTION:**  I have taken the following,  Temporary / Permanent  immediate actions to reduce recurrence. | | Explain: | | | | |
| I recommend the following actions(s) to prevent recurrence; and anticipate completion by:   /  / |  | | | | | |
| **Department Head’s Comments:** (Appropriateness of Cause & Corrective Action) | | | | | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Title:**  **Telephone: (****)** **-****Date:****/****/** | |
| **Corrective Action/Follow up** By Department Head: | | | | | | **Date:** **/****/** |
| **Reviewed by Office of Safety:** | | | | | | **Date:** **/****/** |