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| 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:** **/****/** |