

# ACCIDENT INVESTIGATION FORM

Name of Injured Person: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Department: \_\_\_\_\_ Location of Injury: \_\_\_\_\_

Brief Description of Accident:

Nature of Injury (describe all body parts affected):

Was Training Provided?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>
Were established procedures followed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>
Were tools or equipment adequate for task?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>
Were environmental conditions a factor in the incident?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	NA	<input type="checkbox"/>

Elaborate on Responses:

Proposed Corrective Action:

Supervisor: \_\_\_\_\_ Date of Report: \_\_\_\_\_

Signature: \_\_\_\_\_

**IIPP-Appendix D  
March 2006**

Completed copies of this form should be routed to the department Safety Coordinator and kept in department files for at least three years.