

INCIDENT INVESTIGATION FORM

I. Incident Information

Date of Accident _____ Time _____ AM/PM Days of Week _____ Department/Location _____
S M T W T F S

II. Injured Person(s)

Name: _____

Student Faculty Staff Other _____

Nature of Injury

Strain/Sprain Bruising Dislocation Other: _____
 Fracture Scratch/Abrasion Internal _____
 Laceration/Cut Amputation Foreign Body _____
 Burn/Scald Chemical Reaction _____

Location of Injury: _____

Treatment

First Aid
 Campus Nurse
 Emergency Room
 Dr's Office
 Hospitalization

Name and Address of Treating Physician of Facility

III. Damaged Property

Property, Equipment, or Material Damaged: _____ Description of Damage: _____

Object or Substance Causing Damage: _____

Describe What Happened (Attach Photographs or Diagrams If Necessary):

IV. Root Cause Analysis (Check All That Apply Based on Observable/Known Facts)

<input type="checkbox"/> Improper Work Technique	<input type="checkbox"/> Poor Workstation/Process Design/Layout	<input type="checkbox"/> No Written Procedure/Policy
<input type="checkbox"/> Safety Rule Violation	<input type="checkbox"/> Congested Work Area	<input type="checkbox"/> Safety Rule not Enforced
<input type="checkbox"/> Improper PPE or PPE Not Used	<input type="checkbox"/> Hazardous Substance	<input type="checkbox"/> Operating Without Authority
<input type="checkbox"/> Fire or Explosion Hazard	<input type="checkbox"/> No PPE	<input type="checkbox"/> Failure to Warn/Secure
<input type="checkbox"/> Inadequate Ventilation/Lighting	<input type="checkbox"/> Insufficient Worker Training	<input type="checkbox"/> Operating at Improper Speeds
<input type="checkbox"/> Improper Material Storage	<input type="checkbox"/> Improper Maintenance/Inspection	<input type="checkbox"/> Insufficient Supervisor Training
<input type="checkbox"/> By-Passed Safety Device/Guard	<input type="checkbox"/> Improper/Inadequate Tools/Equipment	<input type="checkbox"/> Insufficient Knowledge of Job
<input type="checkbox"/> Slippery Conditions	<input type="checkbox"/> Inadequate Job Planning/Scheduling	<input type="checkbox"/> Inadequate Supervision
<input type="checkbox"/> Improper Lifting	<input type="checkbox"/> Poor Housekeeping	<input type="checkbox"/> Excessive Noise
<input type="checkbox"/> Horseplay/Unsafe Act of Other	<input type="checkbox"/> Drug/Alcohol Use	<input type="checkbox"/> Service Machine in Motion
<input type="checkbox"/> Inadequate Fall Protection	<input type="checkbox"/> Inadequate Guarding of Hazard	<input type="checkbox"/> Unnecessary Haste
<input type="checkbox"/> Improper Loading/Placement	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Unknown

V. Incident Analysis

Using the Root Cause Analysis List on the Previous Page, Explain the Cause(s) of the Incident in as Much Detail as Possible, Focusing on Known Facts.

How Bad Could the Accident Have Been?

- Very Serious Serious Minor As Bad As Likely

What is the Chance of the Accident Happening Again?

- Very Likely Likely Possible Unlikely

VI. Preventative Actions

Describe Actions That Will Be Taken to Prevent Recurrence	Deadline	Responsible Party
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VII. Investigation Team

Signature	Name	Position	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

THIS FORM SHOULD BE SUBMITTED, EITHER IN HARD COPY OR ELECTRONICALLY, TO (1) THE HEAD OF THE AFFECTED DEPARTMENT, (2) THE CO-CHAIRS OF THE SAFETY COMMITTEE, AND (3) THE UNIVERSITY LABORATORY SAFETY COORDINATOR OR DIRECTOR OF THE ENVIRONMENTAL AND OCCUPATIONAL SAFETY, AS APPROPRIATE.