OCCUPATIONAL ACCIDENT, INJURY OR ILLNESS INVESTIGATION REPORT

Department:____

Supervisor's Name/Phone:________________________________

Person(s) involved: (include titles)____________________________

____

____

Location:__________________________ Time:________ Date:________

Task being performed when accident occurred:________________________

____

____

NOTE: This form is intended to serve only as a local record of the investigation conducted within the department. Should an injury or illness occur, required forms must be submitted to the Department of Workers Compensation (DWC) as outlined in the Workers' Compensation Manual for Supervisors. Call 643-7921 if copies are not available in your department. Also, an IIPP Form 4, "Hazard Correction Report" must be completed in conjunction with any accident, injury or illness.

Describe the accident, illness, or injury and the probable root cause(s) of the incident. Include the nature of the injury or illness, any eyewitness accounts, and any property damage which may have occurred. Be sure to include the names and phone numbers of any witnesses. Attach a separate sheet if necessary.

____

____

____

Describe what corrective actions need to be taken to ensure this type of incident does not recur. Also, include the name(s) and phone number(s) of those who will ensure that these corrective actions are done in a timely manner.

____

____

____

______________________________ __________________

Signature of Supervisor Conducting Investigation Date

______________________________ __________________

Signature of Department Safety Coordinator Date

(Do not sign until a thorough review of the incident by the Safety Committee is complete and corrective actions are in place.)

IIPP—Form 5 Completed copies of this form must be routed to the Safety Committee and kept on file for at least one year.
Rev. 10/02/01

For questions on any item, please contact your Department Safety Coordinator or call EH&S at 642-3073.