ATTACHMENT 2

ACCIDENT REPORT AND INVESTIGATION FOR EMPLOYEE INJURIES ONLY

(Part 1 Must Be Completed Immediately And Sent To Appropriate Personnel)

Part 1

Name of Employee Injured: ________________________________ Sex:___ SS#: ____________

Date of Birth: ___________ Mailing Address: ____

Home Phone: ___________ Date lost time began:____________

Marital Status: _________ No. of Dependent Children: _______

Spouse's Name:___________________________________

Date of Injury: ________________ Time of Injury: __________ a.m. p.m.

Date Employee Reported Injury:_______________

Treating Doctor's Name: _________________________

Address: ________________________________

Ph #_____________

Was employee doing his/her regular job? ___Yes ___No If no, why was job being performed:

____

____

Address or Location Where Injury Occurred:

____

Name(s) of Witness to Injury (name, address, ph.#) (Attach additional sheet if necessary)

____

____

Nature of Injury: ____ Absorption, Ingestion, Inhalation; ____ Caught In, Under or Between; ____ Cut, Puncture, Scrape;____ Foreign Matter in Eye; ____ Slip, Trip, Fall; ____ Strain; ____ Struck Against; ____Motor Vehicle; ____ Other

Part of Body Injured: ___ Right ___ Left ___ Leg ___ Head ___ Arm ___ Back ___ Hand ___ Shoulder ___ Neck

Employee's Description of Injury (Attach additional sheet if necessary)

____

____

____

______________________ ______________ __________________ ______

Employee's Signature Date Supervisor's Signature Date

PART 2

Supervisor's Findings/Remarks (Attach additional sheet if necessary)

____

____

____

Basic Cause and Contributing Factors (check all that apply)

PERSONNEL		EQUIPMENT	ENVIRONMENT
___Unsafe Act	___ Running/Rushing/Acting in Haste	___Defective Tools	___Lighting
___Inexperience	___ Lack of Awareness	___ Improper Tools	___ Housekeeping
___Unsafe Act of Other	___ Understaffed	___ PPE: Used – Yes No	___Weather Related
___Lack of Training	___ Horseplay/Distractive Action		

Explain/Other: ____

Date of Investigation: ____________________

________________________________ ____________

Supervisor's Signature Date

Corrective Action/Preventive Measures Taken or Recommended (Attach additional sheet if necessary)

____

The preventive measure(s)/corrective action(s) is ___ temporary. ___ permanent.

Employee responsible for ensuring corrective measures/actions are taken:

____

Date Corrective/Preventive Measures Completed: ______________________________

Department Head's Signature_____________________________________

Date________________________________

Associate Facilities Manager Signature ____

Date ________________________________