

INJURY INVESTIGATION REPORT

COMPANY / DIVISION / DEPARTMENT

LOCATION WHERE INJURY OCCURRED	DATE OF HIRE
NAME OF INJURED WORKER	NORMAL OCCUPATION OF INJURED
INJURED WORKER'S DATE OF BIRTH	INJURED WORKER'S HOME PHONE NUMBER

WAS EMPLOYEE PERFORMING NORMAL OCCUPATION AT THE TIME OF INJURY? Yes No

DATE OF INJURY	TIME OF INJURY AM	DATE / TIME REPORTED TO YOU AM
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DID EMPLOYEE LEAVE WORK?

AM

DID EMPLOYEE RETURN TO WORK?

AM

NAME (S) OF WITNESSES

NAME OF DOCTOR OF HOSPITAL WHERE INJURED WAS TREATED (ADDRESS/CITY)

NOTE: When injured returns to work, obtain return to work certificate from doctor and send to main office.

WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific, identify tools, equipment or materials the employee was using.)

How did the injury or exposure occur? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use a separate sheet if necessary).

OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (i.e. the machine employee struck against or which struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin; in cases of strains, the object he was lifting, pulling, etc.)

Describe the injury or illness (i.e. cut, strain, skin rash, fracture, etc.)

Part of body effected (i.e. back, left wrist, right eye, etc.)

WHAT DID THE EMPLOYEE DO OR FAIL TO DO THAT CONTRIBUTED TO THE INJURY?

WHAT ACTIONS HAVE OR WILL BE TAKEN TO PREVENT RECURRENCE? Check below when completed.

1.

2.

3.

4.

INVESTIGATION CONDUCTED BY:

TITLE

DATE