ACCIDENT INJURY INVESTIGATION FORM
STEPHENS COUNTY
BOARD OF COMMISSIONERS

DEPARTMENT _____

DATE ACCIDENT OCCURRED:_____ TIME ACCIDENT OCCURRED_____

DATE/TIME ACCIDENT REPORTED_____

SUPERVISOR_____

LOCATION OF ACCIDENT_____

NAME OF INJURED PERSON: _____
LAST FIRST MI

JOB TITLE_____

EMPLOYEE ADDRESS_____EMPLOYEE PHONE#_____

NAMES OF WITNESSES:

Last Name_____First Name_____Title_____

Address(if not an employee)_____

Last Name_____First Name_____Title_____

Address(if not an employee)_____

INJURED PERSON'S SUPERVISOR AT TIME OF THE INJURY: (if different from above)

LAST NAME_____FIRST NAME_____MI_____

TITLE_____

DID EMPLOYEE RECEIVE MEDICAL ATTENTION: _____YES_____NO

IF YES GIVE NAME AND ADDRESS OF MEDICAL FACILITY:

_____

_____

DESCRIPTION OF INJURY:

_____

_____

_____

CAUSE OF INJURY:

_____

_____

_____

TYPE OF EQUIPMENT EMPLOYEE WAS USING:

_____

_____

INJURED EMPLOYEES DESCRIPTION OF ACCIDENT:
(including circumstances leading up to the accident)

_____

_____

_____

_____

_____

NUMBER OF LOST WORK DAYS: _____

SUPERVISORS EVALUATION:

Has a similar accident of injury happened before?
Yes_____No_____If yes, when_____

Did you know that the employee was doing this job when the accident or injury occurred?
Yes_____No_____

Should the employee be doing this job? Yes_____No_____

Was the employee trained to do this job? Yes_____No_____

Was the employee doing the job correctly when the accident/injury occurred?
Yes_____No_____

Were the conditions and/or equipment efficient and safe? Yes_____No_____

Has the employee done the job correctly in the past? Yes_____No_____

Has the employee ever been corrected or restrained because he/she did the job incorrectly?
Yes_____No_____

Did any obstacles keep the employee from doing the job safely?
Conflicting procedures: Yes____No____
Conflicting orders:Yes____No____
Lack of equipment: Yes____No____
Rush to finish the job: Yes____No____

Has the employee been under any stress? Yes_____No_____

Are there any morale problems among employees? Yes_____No_____

Was the job procedure awkward or unsafe? Yes_____No_____

Was personal protective equipment required for performing this job?
Yes_____No_____
Was it used? Yes_____No_____
Was it used correctly? Yes_____No_____

Is the job boring? Yes_____No_____

Was the accident preventable? Yes_____No_____

RECOMMENDATIONS FOR PREVENTING THIS ACCIDENT FROM RECURRING IN THE FUTURE:

_____

_____

SIGNATURES:

_____
DEPARTMENT HEAD OR SUPERVISOR

_____
EMPLOYEE