



Incident Investigation Form

Last Name:	First Name	Occupation/Job Title	Yrs. Experience in Occupation
Full Address:			
City/Town			Postal Code
Department		Date of Occurrence	Time
Location		Date Reported	Time
<input type="checkbox"/> Hazardous Situation <input type="checkbox"/> Incident <input type="checkbox"/> First Aid <input type="checkbox"/> Health Care <input type="checkbox"/> Lost Time <input type="checkbox"/> Critical Injury			
Describe what happened and, if applicable, describe injury. Attach an incident diagram, if appropriate.			
Describe the nature, date and time of first aid treatment, if applicable.			
Part of Body Injured (Indicate "R", "L", or "B", where applicable)			Signature of person reporting incident
<input type="checkbox"/> Head	<input type="checkbox"/> Lower back	<input type="checkbox"/> Hand/fingers	<input type="checkbox"/> Ankle/foot
<input type="checkbox"/> Eye	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Hip	<input type="checkbox"/> Other
<input type="checkbox"/> Neck	<input type="checkbox"/> Elbow	<input type="checkbox"/> Upper leg	
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Lower Arm	<input type="checkbox"/> Knee	
<input type="checkbox"/> Upper back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Lower leg	
Type of Incident			
Check off (✓) statements that best describe the incident:			
<input type="checkbox"/> Repetitive Strain	<input type="checkbox"/> Slip/fall	<input type="checkbox"/> Exposure to	
<input type="checkbox"/> Acute Strain (lifting, pulling, carrying)	<input type="checkbox"/> Vehicle	<input type="checkbox"/> Other (explain)	
<input type="checkbox"/> Caught in/under/between	<input type="checkbox"/> Client/employee action		
<input type="checkbox"/> Struck, contacted by/with/against	<input type="checkbox"/> Cut/bruise		
Witnesses			
Name			Telephone
Address			
Name			Telephone
Address			
Physician's Name			Telephone
Address			

Remember to attach witness(es) statement(s) on the Witness Statement form.

Causes: Check (✓) all that are applicable

Conditions

- Congestion or restricted action
- Poor housekeeping; disorderly workplace
- Slip/trip hazards
- Lack of or inappropriate furniture/equipment
- Design or arrangement of furniture/equipment
- Defective furniture, tools, equipment or materials
- Inadequate or excessive illumination
- Inadequate ventilation
- Excessive noise
- Inadequate or improper protective equipment
- Fire and explosion hazards
- Inadequate warning systems
- Irrate client/employee action
- Adverse weather
- Other (explain):

Practices

- Improper body position/posture
- Tasks not varied/micro breaks not taken
- Unnecessary rushing
- Improper lifting
- Unsafe loading/placement
- Using defective equipment
- Using equipment improperly
- Altering or modifying equipment
- Not using personal protective equipment or failing to use it properly
- Not following appropriate procedures
- Inappropriate conduct
- Hazardous personal attire
- Other (explain):

What are the reasons for the existence of these practices and/or conditions?

Prevention/Corrective Action

Actions to prevent incident recurrence. Check (✓) those actions taken to prevent recurrence. Mark with (P) other corrective actions decided upon or planned but not yet carried out. More than one item may apply.

- | | |
|--|--|
| <input type="checkbox"/> Training/instruction of person involved | <input type="checkbox"/> Request ergonomic assessment |
| <input type="checkbox"/> Improve work procedures | <input type="checkbox"/> Request environmental assessment |
| <input type="checkbox"/> Inform staff/managers of safe work procedures | <input type="checkbox"/> Correction of work area |
| <input type="checkbox"/> Perform job safety analysis | <input type="checkbox"/> Recommend development/improvement to training/OHS program |
| <input type="checkbox"/> Inform staff/managers of hazard and how to protect themselves | <input type="checkbox"/> Reassess work standards |
| <input type="checkbox"/> Notify appropriate individuals | <input type="checkbox"/> Reassignment of person |
| <input type="checkbox"/> Improve engineering/design | <input type="checkbox"/> Improve housekeeping |
| <input type="checkbox"/> Improve inspection procedures | <input type="checkbox"/> Other (describe): |
| <input type="checkbox"/> Tools, equipment, furniture repair or replacement | |

Remember that ALL corrective action must be documented on the Corrective Action form.

Describe actions taken.

Investigated by:

Manager's Signature	Name (print)	Date (dd-mmm-yyyy)
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Review by:

Director's/Program Head's Signature	Name (print)	Date (dd-mmm-yyyy)
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