Use this form to document information about an accident or incident. Fill out an investigation report as soon as possible. Note: this form is for use within your company. It is not intended to replace DCBS Form 801: *Worker’s and Employer’s Report of Occupational Injury or Disease*.

Employee(s) name(s):

Time & date of accident/incident:

Job title(s) and department(s):

Supervisor or lead person:

Witnesses:

Brief description of the accident or incident:

Body part affected:

Did the injured employee(s) see a doctor? (     ) Yes (     ) No

If yes, did you file an employer’s portion of a worker’s compensation form? (     ) Yes (     ) No

Did the injured employee(s) go home during their work shift? (     ) Yes (     ) No

If yes, list the date and time injured employee(s) left job(s):

Supervisor’s Comments:

What could have been done to prevent this accident/incident?

Have the unsafe conditions been corrected? (     ) Yes (     ) No

If yes, what has been done?

If no, what needs to be done?

Employer or Supervisor’s signature:

Date:

Additional comments/notes: