Use this form to help you investigate workplace accidents or incidents. 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*.

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| --- | --- | --- | --- |
| Company: |  | Report no.: |  |
| Operation: |  | Investigator |  |
| Name of accident victim: |  | Victim’s job title: |  |
| How long has accident victim been with this company? |  | How long on this job? |  |
| (Attach this information for each additional person injured.) |
| Witnesses: |
| Name: |  | Name: |  |
| Name: |  | Name: |  |
| Name: |  | Name: |  |
| When did the accident occur? | Date: |  | Time: |  | Shift: |  |
| Where did the accident occur? | Department: |  | Location: |  |
| What happened? (Describe sequence of events and extent of injury. Attach separate page if necessary.) |
| Has a similar accident ever occurred? [ ]  Yes [ ]  No If yes, when? |  |
|  |  |
| What caused the accident?List all causes and contributing factors, which might include lack of supervision, inadequate training, poor equipment maintenance, and inadequate policy. |
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|  |  |
| List each corrective action to be taken. Who will do it and when will it be done? |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |
| 6. |  |
| 7. |  |

**Attach photographs, sketches of the scene, or other relevant information.**

|  |  |  |  |  |  |
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| Prepared by: |  | Title: |  | Date: |  |