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*.)

### Employee portion

|  |  |  |  |
| --- | --- | --- | --- |
| Employee name: |  | Employee work phone: |  |
| Work unit: |  | Work section: |  |
| Supervisor name: |  | Supervisor work phone: |  |
| Length of service in present position: [ ]  Less than 6 months [ ]  6 months-1 year [ ]  1-2 years [ ]  2-3 years 3-5 years [ ]  More than 5 years |
| Exact location of accident/incident: |  |
| Accident/incident date: |  | Time: |  | [ ]  a.m. [ ]  p.m. |
| Witnesses  | Name: |  | Phone: |  |
| ([ ]  check if no witness) | Name: |  | Phone: |  |
| Body part affected [ ]  Neck [ ]  Shoulder(s) [ ]  Elbow(s) [ ]  Wrist(s)/hand(s)(check all that apply) [ ]  Thigh(s) [ ]  Lower leg(s) [ ]  Ankle(s)/foot(feet) [ ]  Knee [ ]  Hip [ ]  Upper back [ ]  Lower back [ ]  Chest/abdomen |
|  [ ]  Other: |  |
| Task that led to the incident: [ ]  Driving [ ]  Lifting [ ]  Carrying [ ]  Pushing/pulling [ ]  Keyboarding [ ]  Climbing [ ]  Reaching [ ]  Handling [ ]  Bending [ ]  Twisting |
|  [ ]  Other: |  |
| Describe accident/incident in detail (use additional sheets if necessary): |
| Employee signature: |  | Date: |  |

### Supervisor portion

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Reported to: |  | Date: |  | Time: |  | [ ]  a.m. [ ]  p.m. |
| Supervisor’s description of incident (what happened and why): |
| Corrective action:  |
| Employee signature: |  | Date: |  |