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TO REPORT AN ACCIDENT:
CALL CSG
1-800-293-9795

INCIDENT INVESTIGATION REPORT
Jackson Township

☐ **RECORD ONLY**
(Please check only if no medical treatment)

Part I: To be completed by Employee

Last Name: _____ First Name: _____ Initial: _____

Home Address: _____

Home Telephone: _____ Date of Birth: _____ ☐M / F☐

Social Security No: _____ Marital Status: _____

Department: _____ Title: _____ Is employee summer seasonal? ☐Yes ☐No

Date of Hire: _____ Number of Hours Worked per Week: _____

Date of Accident: _____ Day: _____Time:_____☐A.M. P.M.☐

Were you working at the time of accident? Yes ☐ No ☐ Shift Start Time: _____

Did accident occur on employer's premises? Yes ☐ No ☐ Exact location of accident: _____

Weather conditions: Dry: _____ Wet: _____ Snow: _____ Ice: _____ Other: _____

List all materials being used at time of accident: _____

Employee's description of accident: _____

_____

_____

Specific activity engaged in at time of accident: _____

Description of injury (be specific): _____

_____

_____

Witness name(s) and telephone numbers:

_____

_____

Was immediate medical attention given? _____ If yes to above. Name of treating physician: _____

Employee's Signature: _____ **Date:** _____

Part II: To be completed by Manager/Supervisor

Injury/Illness Type (circle all that apply):

1. Abrasion
2. Puncture
3. Laceration
4. Crushing
5. Contusion
6. Poisoning
7. Burn (Thermal)
8. Burn (Chemical)
9. Concussion
10. Dislocation
11. Fracture
12. Occupational Disease
13. Electric Shock
14. Heat/Cold Stress
15. Strains & Sprains
16. Multiple Injuries
17. Respiratory Condition
18. Other:_____

Object/Equipment/Substance Inflicting Injury/Illness (Circle all that apply):

1. Stairways
2. Ladder, scaffold
3. Furniture, fixtures
4. Walking Surface
5. Equipment
6. Sharp Objects
7. Moving Objects
8. Other object
9. Motor Vehicle
10. Hand tool
11. Other machinery
12. Interaction with others
13. Chemicals
14. Insect, plant, animal
15. Other_____

ANALYSIS: What in your opinion was or were contributing cause(s)? Circle appropriate number(s) below.

UNSAFE ACT OR CONDITION

1. Improper lifting
2. Fatigue or poor physical condition
3. Taking incorrect position
4. Using unsafe equipment
5. Incorrect equipment use
6. Using material (e.g. chemical) incorrectly
7. Improper or Failure to use PPE
8. Unsafe movement
9. Failure to maintain equipment
10. House keeping
11. Failure to secure or warn
12. By-passing safety features
13. Operating without authority
14. Other (Describe) _____

BASIC CAUSE

1. Knowledge/Training
2. Employee Selection/Placement
3. Supervision
4. Engineering Practices
5. Personal Protective Equipment
6. Inspection/Maintenance Programs
7. Purchasing Specs. of Equipment
8. Employee Inattention
9. Standards/Practices may need improvement
10. Employee attitude/behavior
11. Drug and/or alcohol
12. Other (Describe)

Describe clearly what happened. For motor vehicle crash, attach diagram and/or Police Report.

_____

_____

Date Accident Reported to Supervisor: _____

What steps were taken to prevent a similar occurrence in the future? _____

_____

Was safety equipment provided/used? _____

What safety training/equipment may have helped to prevent the accident? _____

_____

Supervisor Name: _____ Signature: _____ Date: _____

Part III: To be completed by Incident Review Committee

Further Investigation Needed: ☐ Yes ☐ No

COMMENTS:

_____

_____

_____

_____

Reviewed by: _____ Date: _____

Complete sections I & II, and forward to Personnel via fax or email