ACCIDENT INVESTIGATION REPORT

CRITICAL INJURY OR FATALITY FORM

| Employer: | Department: |
| --- | --- |
| Exact Location: | Date of Occurrence: | Time: |
| AM | PM |
| Report issued by: | Occupation: | Date: |

**Accident Description**

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**Description of the machinery, equipment or procedure involved**

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**Injured Employee**

| Employee’s Name: | Date Hired: | Time On Job: | Age: |
| --- | --- | --- | --- |
| Occupation: | Nature Of Injury: | Part Of Body Injured: |

**Witnesses**

| Name | Address | Phone |
| --- | --- | --- |
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**Employees and Supervisors Involved**

| Name | Address | Phone |
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**Physician / Surgeon / Medical Practitioner who attended the injured employee**

| Name | Address | Phone |
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**Actions Taken to Prevent Recurrence**

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| Issued By (Print): |  | Reviewed By (Signature): |  | Date: |
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| Issued By (Print): |  | Reviewed By (Signature): |  | Date: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Witness Printed Name |  | Witness Signature |  | Date: |
|  |  |  |  |  |
| Interviewer Printed Name |  | Interviewer Signature |  | Date: |