



## Environmental Health & Safety Accident & Incident Investigation Form

### Section A

Department _____ Equipment Involved <input type="checkbox"/> Y <input type="checkbox"/> N List specific equipment here: _____	<input type="checkbox"/> Accident <input type="checkbox"/> Near Miss <input type="checkbox"/> Injury – <i>If there was an injury, you must also fill out <b>Section B</b> of this form</i>
Name of Responsible Party _____	WFU Job Title _____
Person You Reported Accident/Incident/Injury to _____	
Employee <input type="checkbox"/> Contractor/Subcontractor <input type="checkbox"/> Student <input type="checkbox"/>	

<b>Accident Type</b>		
<input type="checkbox"/> Struck By	<input type="checkbox"/> Slip, Fall	<input type="checkbox"/> Contact with Electrical Current
<input type="checkbox"/> Struck Against	<input type="checkbox"/> Caught In, On or Between	<input type="checkbox"/> Exposure to Temperature Extremes
<input type="checkbox"/> Overexertion	<input type="checkbox"/> Strain, Sprain	<input type="checkbox"/> Chemical Exposure
<input type="checkbox"/> Vehicle Accident	<input type="checkbox"/> Other	<input type="checkbox"/> Penetration
		<input type="checkbox"/> Loss of Consciousness
		<input type="checkbox"/> Heavy Equipment

<b>Accident Cause</b>	<b>Corrective Action</b> (Define action taken on back of form)	<b>Date Completed</b> (or Estimate)
<input type="checkbox"/> Condition	<input type="checkbox"/> Instruction/Training	Date _____
<input type="checkbox"/> Inappropriate or Improper Attitude	<input type="checkbox"/> Motivation/Discipline	Date _____
<input type="checkbox"/> Human Limitation (Permanent)	<input type="checkbox"/> Proper Placement	Date _____
<input type="checkbox"/> Failure to Use Appropriate PPE	<input type="checkbox"/> Repair/Eliminate	Date _____
<input type="checkbox"/> Rough Housing	<input type="checkbox"/> Policy Change(s)	Date _____
<input type="checkbox"/> Inadequate Training	<input type="checkbox"/> Use of Equipment	Date _____
<input type="checkbox"/> Other	<input type="checkbox"/> Other	Date _____

Chemicals/Equipment/Machinery/Tools/Materials Involved \_\_\_\_\_

Property Damage  Yes  No

Vehicle Accident  Yes  No

Personal Injury  Yes  No *If yes, complete Section B*

Accident Report by Law Enforcement  Yes  No *If yes, attach a copy to this form.*

Specific Location Where Event Occurred
Operation Being Performed at Accident Site and its Frequency
Other Comments or Information Including Witnesses/Witness Statements
Describe how accident/near miss occurred (give details) and include accident photos, sketches, other details. (add pages where necessary)

Describe Corrective Action Taken and Completion Date <hr/> <hr/> <hr/> <hr/>
Date:  <i><b>You must attach proof of implemented Corrective Action</b></i>

**Section B** (you do not have to fill out this section if there was **NO** injury involved)

Injury/Illness Description Including Part of Body		
First Aid Given? <input type="checkbox"/> Yes <input type="checkbox"/> No	By Whom?	
Sent to Doctor/Medical Facility <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Doctor/Hospital	Authorized by Whom?
Was the employee involved <b>written out</b> of work by the doctor/medical facility?  <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, include dates below: _____ thru _____ 2009	Was the employee involved <b>restricted</b> from regular duty by the doctor/medical facility?  <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, include dates below: _____ thru _____ 2009	Date of Initial Visit:
Comments		

<b>Supervisor</b>	(Print Name)	Signature	Date
<b>Injured</b>	(Print Name)	Signature	Date
<b>EH&amp;S Director</b>		Signature	Date