DAWSON COUNTY (Preliminary)
INCIDENT/ACCIDENT/INJURY INVESTIGATION REPORT

Instructions

1. Report to be completed by employee immediately for any on-the-job incident/accident/injury without regard to severity.
2. Employee must complete Part I and Supervisor must complete Part II (Supervisor: Make 2 copies: 1 for employee and keep 1 copy for your files)
3. Forward Original to the Payroll Administrator (Payroll Adm needs to complete any necessary worker's compensation, keep a copy and forward the original to the Safety Director.
4. **If medical attention or time off due to injury occurs after the submission of this report, Notify your supervisor immediately.**

***Part I* - To be Completed by the Injured Employee (Or Supervisor if the employee is not available)**

Employee Name: __________

Department: __________ Job Title: __________

Date of Injury: __________ Time of Injury: __________ a.m/p.m.

Place of Injury: Specific __________

Was this at the Employer's Premises? ☐ Yes ☐ No

If not, please specify the address: __________

Name(s) of all witness(es) to your injury: __________

Names of other party(s) involved: __________

Were you on duty at the time of injury: ☐ Yes ☐ No

How did the injury occur (describe what happened): __________

What body part was affected: (head, arm, leg, back, etc.) __________

Extent of injury: __________

Was first aid administered: ☐ Yes ☐ No Did you require professional medical care: ☐ Yes ☐ No

If Yes, Hospital Doctor: __________ Date of Visit: __________

Address of Doctor/Hospital: __________ Phone Number: __________

Initial Treatment: ☐ None ☐ Emergency Room ☐ On Site by Employer/Med Staff ☐ Clinic/Dr ☐ Hospital

Was an overnight stay in the hospital required: ☐ Yes ☐ No

Were you off work because of this accident: ☐ Yes ☐ No If yes, 1st work day off, date: __________

Object or activity that directly caused the injury: __________

Was the injury caused by a failure of machine or product: ☐ Yes ☐ No Explain: __________

If applicable, was safety equipment provided: ☐ Yes ☐ No

Who did you report incident/accident to: __________

Was safety equipment used: ☐ Yes ☐ No

How could this incident/accident have been avoided: __________

Employee Signature: __________ **Date:** __________

(If a vehicle was involved also complete "Vehicle Accident/Collision Report" form)

***Part II -* To Be Completed by the Supervisor**

Employee's physical condition prior to incident/accident: ☐ Apparantly normal ☐ Other

If other, please explain: ______

Did you witness the incident/accident: ☐ Yes ☐ No

Describe accident, include the machine, object or substance involved: ______

______

What caused the incident/accident: ______

What could be done to prevent injuries of this type: ______

______

Corrective action taken: ______

______

Supervisor Signature: ______ **Date:** ______

***Part III* - To Be Completed by Safety Director & Safety Committee Members**

Summary of investigation: ______

______

______

______

______

Additional Corrective action proposed: ______

______

______

Further recommendations: ______

______

______

Complete Date: ______

Safety Director Signature: ______ **Date:** ______

Committee Member Signature: ______ **Date:** ______