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Office Use Only

Injury Classification

First Aid _____
Recordable _____
Lost Work Day _____

Subject:	**SH – 8 Incident Investigation Report**	**Page - 1 -**
Issued By:	**Corporate Safety Office**	**Revision 5**

1. Employee Information:

Employee Name: _____ Date of Birth_____

Employee Address : _____

Employee Phone Number_____ Department: _____

Occupation at time of Injury_____

Hire Date_____ Length of Employment(Years): _____

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2. Incident Information:

Date of Incident: _____ Time of Accident: _____ AM PM

Reported by: _____ Date of Report: _____

Reported to: _____ Shift:

Time employee began work: _____ Weather Conditions: _____

Job Number: _____ Job Name: _____

Department/Region: _____ Manager on duty: _____

Location: _____

_____

_____

Near Miss? Yes No

Nature of incident (Check all that apply)

- ❑ Absorption, Inhalation, or Ingestion
- ❑ Chemical Handling
- ❑ Contact with Extreme Temperature
- ❑ Struck by, against
- X Other (explain)_____
- □ Caught In/Between
- □ Contact with Electricity
- □ Overexertion
- □ Slip, Trip, Fall

Supervisor Suspicion: Yes No

Is there a witness? Yes No

Witnesses: _____

Photos taken: Yes No

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How did the injury occur. Being as detailed as possible, describe the area, and acts or conditions that resulted in the incident. (Use reverse side of sheet if necessary). _____

_____

_____

_____

What was the employee doing just before the incident occurred: _____

_____

_____

_____

: _____

_____

_____

_____

3. Injury/Illness/Property Damage Information

Describe the injury to the employee and/or property damage, if applicable. Include type of injury, body part affected, etc. Be as descriptive as possible. (Use reverse side of sheet if necessary). _____

_____

_____

_____

What object or substance directly harmed the employee: _____

_____

Body Fluid Exposure: Yes No

First Aid Given: Yes No If yes, description of first aid: _____

_____

Treatment given away from worksite: Yes No If yes, who/where administered the treatment: _____

Employee taken to hospital: Yes No. If yes, name of hospital: _____

Hospital address: _____

Was employee treated in an emergency room: Yes No

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Was employee hospitalized: Yes No

Suspected Cause: _____

_____

_____

Drug/Alcohol Screen(s) Administered: Yes No

4. Causes Of The Accident

Contributing

1. _____

Why? _____

2. _____

Why? _____

3. _____

Why? _____

Root Cause Of Accident (Note; a 'cause' is an action, i.e., someone did something, or failed to do something.)

_____

_____

Immediate Corrective Action:

1. _____
2. _____
3. _____

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What corrective actions will be taken to keep this type of incident from occurring in the future? (Must address the cause(s) of the accident)

Action	Assigned To	Target Completion Date

Signatures:

Employee_____ Date: _____

Employee's supervisor _____

Supervisor preparing report_____ Date: _____

Area Manager's Signature _____ Date: _____

Witness_____ Date: _____

Witness_____ Date: _____

Routing & Signatures:

Regional Safety Office: _____ Date Received:_____

Regional Manager: _____ Date: _____

Documented in Intelex: _____ Date: _____