

# Incident Investigation Report

## Section I: To be Completed by Employee

Name: \_\_\_\_\_ Department: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Title/  
Occupation: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_

Location: \_\_\_\_\_

### WITNESSES: (name & address)

Witness Incident (1) \_\_\_\_\_  
Statement Form \_\_\_\_\_  
Attached (2) \_\_\_\_\_  
\_\_\_\_\_

### Damaged Property Owned By: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Estimated Cost: \_\_\_\_\_

Describe Incident: \_\_\_\_\_

Attach additional \_\_\_\_\_  
sheets as necessary \_\_\_\_\_  
\_\_\_\_\_

Was this accident preventable? Yes \_\_\_\_\_ No \_\_\_\_\_

How, in your opinion, could this incident have been prevented? \_\_\_\_\_

Employees Signature \_\_\_\_\_

## Section II: To Be Completed By Supervisor

Date: \_\_\_\_\_ Incident Time: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Employee Department: \_\_\_\_\_

Employee Title: \_\_\_\_\_ Supervisor: \_\_\_\_\_

First Aid Given: Yes \_\_\_\_ No \_\_\_\_ If Yes, by whom: \_\_\_\_\_

Describe First Aid Given: \_\_\_\_\_

Sent to Medical Facility: Yes \_\_\_\_ No \_\_\_\_ Facility & Address: \_\_\_\_\_