SH-8 Incident Investigation Report

Date of Report: Report Prepared by:

Employee Information	
Name:	Date of Birth:
Address:	Phone Number:
	Time with Company*:
Occupation at time of Injury:	Department:
Hire Date:	Hours worked daily:
*Do NOT include time as a temp, unless the employee is a temp.	

Incident Information	
Date & Time of Accident:	General Location:
Witnesses:	
Incident Reported to:	Objects Involved in Incident:
Exact Location:	
Body Part Affected:	

SAFETY DEPARTMENT ONLY: Classification

Copy of Police Report required for motor vehicle accidents

○	Report Only (no medical treatment given)	○	Motor Vehicle with Injuries
○	First Aid (treatment given on site only)	○	Motor Vehicle without Injuries
●	Medical Treatment offsite (Specify treatment below)	●	Motor Vehicle Towed

Nature of Incident

CHECK ALL THAT MAY APPLY			
	Absorption, Inhalation, or Ingestion		Contact with electricity
	Chemical Handling		Overexertion
	Contact with extreme temperature		Slip, Trip, Fall
	Struck by/against		

Describe the injury to the employee and/or property damage. Be as descriptive as possible.

Describe what happened. Include any acts or conditions that may have caused the accident.

Contributing Causes

	Cause	Why?
1		
2		
3		
4		
5		

Root Cause of Accident (should be an action)

What Corrective Actions will be taken to prevent this in the future? (Address the causes)

Action	Assigned to	Target Date

Signatures

Employee:	Date:
Employee's Supervisor:	Date:
Supervisor preparing report:	Date:
Area Manager:	Date:
Witness:	Date:
Witness:	Date:
Regional Safety Office:	Date Received:
Regional Manager:	Date:
Corporate Safety Office:	Date: