

ACCIDENT / INCIDENT INVESTIGATION FORM

Organization Name: _____

Injured Worker: _____

Job Title: _____

Near Miss First Aid Administered Medical Treatment Needed

Date of Injury: _____ Time of Injury: _____ AM PM

WITNESSES

Name: _____ Job Title: _____

Name: _____ Job Title: _____

Name: _____ Job Title: _____

Name: _____ Job Title: _____

What happened? (Describe the incident):

Contributing factors:

Corrective action:

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