

Document no:	HR00033
Rev:	A
Effective date:	1/17/2020



Accident Investigation Report

Date of investigation		Injured employee	
Occupation/Department		Date/Time:	
Date of injury		Supervisor	
Where incident occurred:			
Nature of injury reported (injured body part):			
Factors that led up to accident:			
Treatment if any:		<input type="checkbox"/> None <input type="checkbox"/> First Aid Only <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital	
Comments:			
Names and addresses of witnesses and their comments (please use back for additional comments):			
Identify factors which contributed to or caused accident/incident:			
Recommendations for corrective measures:			
Corrective measures taken?	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> To follow up on
			(Date) <input type="checkbox"/>

Employee Signature

Supervisor Signature

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REVISION HISTORY

Rev.	ECO No.	Revision date	Revised by:	Description of Change
Rev.A				First document
Rev.B				
Rev.C				
Rev.D				
Rev.E				