THE CITY of Milford DELAWARE

INCIDENT INVESTIGATION FORM

EMPLOYEE INFORMATION		
Last Name:	First Name:	Middle Name:
Department:		
Job Title:		

HUMAN RESOURCES ONLY			
Address:			
City:		State:	Zip:
SSN:	Phone:	Age:	Sex:
DOB:	Hire Date:	Marital Status:	Dependents:

INCIDENT DESCRIPTION			
Date of Incident:	Time of Incident: AM / PM	Date Reported:	Time Reported: AM / PM

When Did Incident Occur: □ Within 1st Hour of Work □ Between 2nd and 8th Hour □ After 8th Hour of Work

Length of Time on Job: □ In Training □ Less Than 1 Year □ More Than 1 Year

Explain what occurred including all events that led up to and occurred during the event. Include exact location, machine numbers, etc.

Were there any witnesses? YES NO If yes, who?

Was a 3rd party (i.e. subcontractor) directly or indirectly involved? YES NO

Was safety equipment bypassed, not used or improperly used? YES NO

Was medical attention offered? YES NO If yes, check all that apply:

□ 1st Aid on Site □ Occupational Health Clinic/Name: □ Hospital Emergency Room/Name:

□ Employee does not wish to receive outside medical treatment at this time. □ Other:

INCIDENT INVESTIGATION FORM

INCIDENT TYPE

____ Strain While Lifting or Moving Object
____ Struck by Object
____ Forklift or Pallet Jack
____ Fall, Same Level
____ Caught In, Under or Between
____ Other (explain)
____ Slip or Trip (no fall)
____ Overexertion/Strain
____ Struck Against Object
____ Motor Vehicle

BODY PART(S) AFFECTED (circle left or right where applicable)

____ Head
____ Face
____ Lip/Mouth
____ Eye (Lt./Rt.)
____ Ear (Lt./Rt.)
____ Other (explain) ______________________________
____ Neck
____ Trunk/Torso
____ Abdomen
____ Upper Back
____ Lower Back
____ Hip (Lt./Rt.)
____ Shoulder (Lt./Rt.)
____ Upper Arm (Lt./Rt.)
____ Elbow (Lt./Rt.)
____ Forearm (Lt./Rt.)
____ Wrist (Lt./Rt.)
____ Hand (Lt./Rt.)
____ Finger (Lt./Rt.)
____ Thigh (Lt./Rt.)
____ Knee (Lt./Rt.)
____ Shin/Calf (Lt./Rt.)
____ Ankle (Lt./Rt.)
____ Foot (Lt./Rt.)
____ Toe (Lt./Rt.)
____ Respiratory

NATURE OF INJURY/ILLNESS

____ Sprain/Strain
____ Repetitive Trauma (CTDs)
____ Cut/Scrape/Puncture
____ Bruise/Contusion
____ Fracture/Dislocate/Crush
____ Skin Irritation/Dermatitis
____ Burn-Thermal/Electrical
____ Burn-Chemical
____ Foreign Object
____ Heat Stress
____ Hernia/Rupture
____ Other (explain) ______________
____ Concussion
____ Chemical Exposure
____ Amputation

BASIC CAUSE(S) (check all that apply)

____ Unsafe Method Used
____ Spills/Leaks
____ Shortcuts/Save Time
____ Housekeeping/Clutter
____ Using Improper Tool
____ Unguarded/Faulty Equipment
____ Procedure Not Followed Properly
____ Lack of Protective Equipment
____ Other (explain) ______________

ROOT CAUSE(S) (check all that apply)

____ Lack of Procedure
____ Inadequate Procedure
____ Lack of Enforcement/Motivation
____ Lack of Knowledge/Training
____ Inadequate Inspection/Maintenance
____ Other (explain) ______________

CORRECTIVE ACTION

Action Needed	Person(s) Responsible	Expected Completion Date

REQUIRED SIGNATURES

Employee Signature:		Date:
Supervisor Signature:		Date:

The completed form must be returned to Human Resources within 72 hours of reporting the incident.