

ACCIDENT/INCIDENT INVESTIGATION FORM II-1

1. Name: _____ Phone: _____

Involved **Witness** **Employee**

Customer Address: _____

2. Name: _____ Phone: _____

Involved **Witness** **Employee**

Customer Address: _____

3. Name: _____ Phone: _____

Involved **Witness** **Employee**

4. Date of Accident/Incident: _____ Time of Accident/Incident: _____

5. Location of Accident: Store# _____ Area: _____

6. Nature of Injury and/or Property Damage: _____

7. Medical facility/Doctor: _____

8. Describe What Occurred: _____

9. Potential Causes (Check All That Apply):

CONDITIONS	ACTIONS
<input type="checkbox"/> Housekeeping (slippery floors, etc.)	<input type="checkbox"/> Failure to follow standard instructions & rules
<input type="checkbox"/> Congested Areas (aisles, walkways, etc)	<input type="checkbox"/> Not trained adequately
<input type="checkbox"/> Improper stacking/storage of materials	<input type="checkbox"/> Operating without authority
<input type="checkbox"/> Defective/Improper tools	<input type="checkbox"/> Failure to use safety guards on equipment
<input type="checkbox"/> Defective Equipment/Machinery	<input type="checkbox"/> Using defective equipment/tools
<input type="checkbox"/> Lack of Personal Protective Equipment	<input type="checkbox"/> Failure to use Personal Protective Equipment
<input type="checkbox"/> Improper clothing	<input type="checkbox"/> Inattention
<input type="checkbox"/> Lighting, temperature, other environmental factors	<input type="checkbox"/> Horseplay
<input type="checkbox"/> Other (describe)	<input type="checkbox"/> Other (describe)
<input type="checkbox"/> Other (describe)	<input type="checkbox"/> Other (describe)
<input type="checkbox"/> Other (describe)	<input type="checkbox"/> Other (describe)

10. Action Taken to Prevent Reoccurrence: _____

Prepared By: _____

Date: _____