



ACCIDENT INVESTIGATION FORM

City/Member Name:	Date of Report:
Department:	
Name of Claimant:	Date of Accident:

INVESTIGATION	CAUSES	Primary and Contributing Causes of the Accident? (NUMBER EACH CAUSE BY IMPORTANCE)		
	CONTROLS	Short-Term Controls to Prevent Reoccurrence? (CORRESPONDING NUMBERS TO EACH CAUSE)		
LOSS PREVENTION	CORRECTIVE ACTIONS	Corrective Actions to Prevent Similar Claims? (CORRESPONDING NUMBER)	AUTHORITY	ACCOUNTABILITY
			Responsible Person?	Scheduled Correction Date

Supervisor:	Date:
Reviewed by:	Date:
Reviewer's Comments:	