

# ACCIDENT INVESTIGATION FORM

<b>Member Name:</b>	<b>Date of Report:</b>
<b>Name of Employee:</b>	
<b>Department:</b>	<b>Date of Accident:</b>

<b>INVESTIGATION</b>	<b>CAUSES</b>	<b>Primary and Contributing Causes of the Accident? (NUMBER EACH CAUSE BY IMPORTANCE)</b>			
	<b>CONTROLS</b>	<b>Suggestions to Prevent Reoccurrence? (CORRESPONDING NUMBERS TO EACH CAUSE)</b>			
<b>FOLLOW-UP</b>	<b>CORRECTIVE ACTIONS</b>	<b>Corrective Actions to Prevent Reoccurrence? (CORRESPONDING NUMBER)</b>	<b>Responsible Person?</b>	<b>Scheduled Correction Date</b>	<b>Date Complete</b>

<b>Supervisor:</b>	<b>Date:</b>
<b>Reviewed by:</b>	<b>Date:</b>
<b>Reviewer's Comments:</b>	