ALL STATES MECHANICAL

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INCIDENT INVESTIGATION FORM

DATE OF REPORT	
NAME OF EMPLOYEE INVOLVED	
DATE OF INJURY	
JOB SITE WHERE INCIDENT OCCURRED	
ADDRESS WHERE INCIDENT OCCURRED	
SUPERVISOR NAME	
SUPERVISOR SIGNATURE	

DATE FORM RECEIVED	
DATE FORM RETURNED	

Please initial and date appropriate section after review:

SAFETY MANAGER		DATE	
JOB FORMAN		DATE	
HR MANAGER		DATE	

All incomplete and unsigned forms will be returned for completion.
Thank you for your prompt attention getting these completed within 24 hours.

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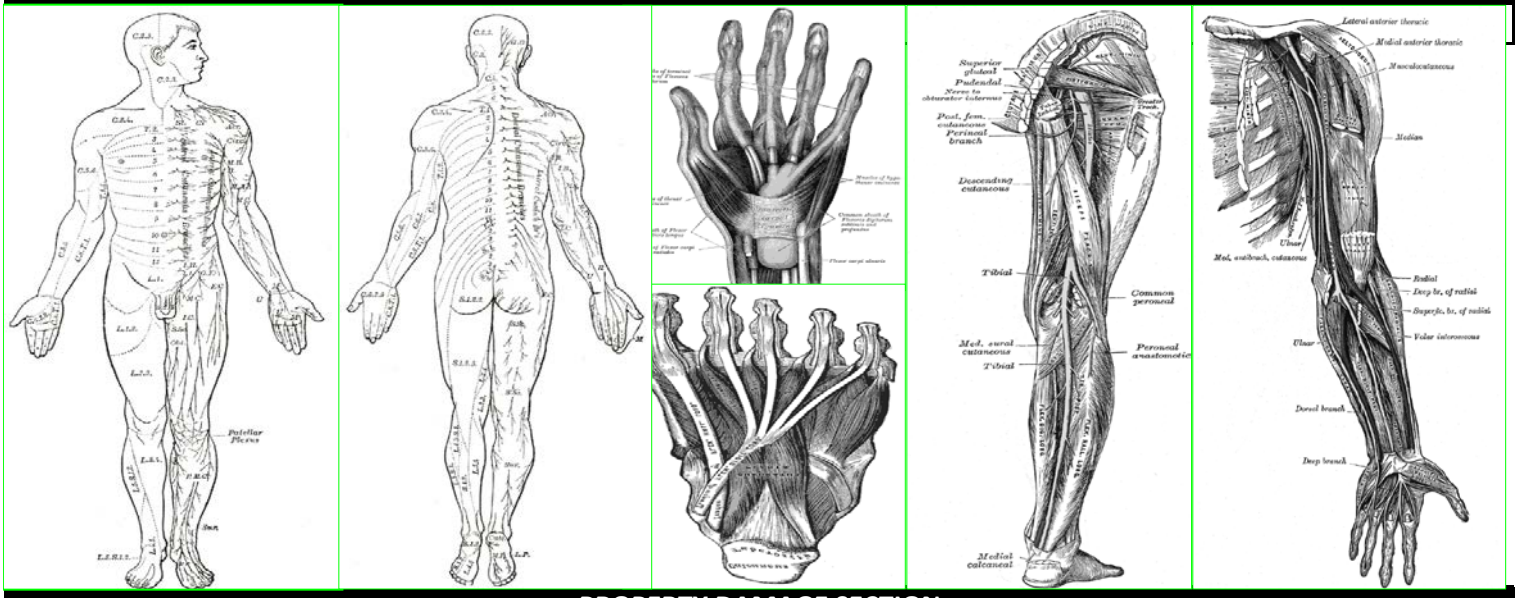
INCIDENT INVESTIGATION FORM

Complete for incidents within 24 hours.	☐ Lost Time Incident ☐ Restricted Duty Case ☐ OSHA Recordable	☐ First Aid ☐ Near Miss ☐ Property Damage	Location (address & Phone) ☐ Check if event occurred off premises

Section 1 - General Information (completed by Supervisor)

Investigation Date:		Date of Injury:		Time of Injury: ____:____ am/pm
Employee Name			Employee Address	
Date of Birth	Sex: M/F	Shift	Time on Job ____ Yrs ____ Mo	Job site incident Occurred
Department:			Date Injury Reported	Employment Status: Hourly/Salaried Non-exempt/Contractor:
Time employee began work ____:____ am/pm	Equipment being used/involved			Task being performed ☐ Routine ☐ Non-routine
Was task being perfomed employee's normal job? YES/NO		Date of Hire	Employee on Overtime? ___ YES ___ NO	
Part(s) of body affected:			Names of witnesses (attach statements to this form)	
Supervisor's Name:				
Was incident immediately reported? ___ YES ___ NO		Who incident was reported to		Assigned job at time of incident

Circle the affected area(s) - To be done by the employee if feasible



PROPERTY DAMAGE SECTION

Equipment Damaged:	$$ Value:
Product Damaged:	$$ Value:
Cause of Loss:	$$ Value:

Section 2 - Injury Causation/Analysis Information (completed by Supervisor)
Describe what the employee was doing just PRIOR to the incident or injury.
Describe how the incident or injury occurred.
Did anyone see this happen? If so, who?
Cause: State the proximate cause of injury (slip, trip, fall, lifting, hit by, CTD, chemical exposure, etc)
Conditions: State any and all unsafe conditions present (anything in the physical environment that contributed to the incident (wet floor, machine guarding, bad lighting, PPE, tool failure, etc.)
Unsafe acts: List any behavior or action of the person involved or other people around that contributed to the incident/injury (did not follow procedure, did not use equipment, horseplay, etc.)
ROOT CAUSE(S) ANALYSIS: List the root cause and how the root cause was determined using the 5 WHY PROCESS
WHY #1
WHY #2
WHY #3
WHY #4
WHY #5
ROOT CAUSE(S):

Section 3 - Injury Causation/Analysis Information (completed by Supervisor)

What short-term actions were you able to take to prevent immediate recurrence?

ROOT CAUSE	CORRECTIVE ACTION	RESPONSIBILITY	DATE COMPLETED

I have reviewed the information in this incident investigation.

Employee _____ Date _____

Supervisor _____ Date _____

Reviewed by HR Manager _____ Date _____

Reviewed by Safety Manager _____ Date _____

SECTION 4 - REVIEW (COMPLETED BY SAFETY DEPARTMENT ONLY)

Treating Provider information:

Name: _____

Address: _____

Phone: _____

Provider selected by: _____

Number of recordable injuries this employee has had in the past year:

Did EMS respond? ___ YES ___ NO | Was employee hospitalized overnight? ___ YES ___ NO

Employee Social Security Number:

Safety Alert needed? ___ YES ___ NO If yes, please attach to the investigation

Drug/Alcohol Test Done? __YES __NO | Claim Filed with Insurer? ___YES ___NO | Claim No:

Basic Cause (check one)

___ Inadequate training
___ Lack of knowledge or skill
___ Engineering/Human Factors
___ Inadequate equipment
___ Job Analysis/Job Procedures
___ Poor employee placement
___ Inadequate PPE
___ Other - please specify:

___ Inadequate feedback system
___ Inadequate hazard detection/correction
___ Inadequate rules, practices or enforcement
___ Unsafe methods
___ Lack of attitude or motivation
___ Physical or mental problems
___ Inadequate or missing equipment

Was this incident due to a non-conformance to rules, processes or procedures? YES/NO

If yes, fill out the non-conformance investigation.

EMPLOYEE STATEMENT

Please describe what happened, why you think it happened and what could have been done or should be done to prevent the incident from occurring again. Attach additional sheets, sketches, photos, etc if necessary.

I certify that the above information is true to the best of my knowledge.

Employee Signature:	Print Name:	Date:
Translator Signature:	Print Name:	Date:

WITNESS STATEMENT

Please describe what happened, why you think it happened and what could have been done or should be done to prevent the incident from occurring again. Attach additional sheets, sketches, photos, etc if necessary.

I certify that the above information is true to the best of my knowledge.

Witness Signature:	Print Name:	Date:
Translator Signature:	Print Name:	Date:

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NON-CONFORMANCE INVESTIGATION FORM

NON-CONFORMANCE: an incident(s) in which there was a failure to comply with a company policy, procedure, or accepted regulatory standard, practice or behavior. Examples could include things like failing to lockout equipment, failure to inspect a PIT before use, mismatched fall protection equipment components, failure to accurately complete a permit, failure to correct witnessed unsafe behaviors, etc.

Please describe the non-conformance(s):

Please circle any appropriate job factors affecting the non-conformance:

KNOWLEDGE STRESS ENGINEERING TOOLS EQUIPMENT SUPERVISION

Did a personal or job factor not mentioned above contribute to the non-conformance? YES/NO
If yes, please explain what factor(s) were involved.

Corrective Actions - Must correspond and address ALL unsafe acts, conditions and/or Job Factors above
Immediate action(s) taken - Describe action AND date of completion

Scheduled Action(s) to be taken - Describe action with estimated date of completion.

Preventative Action(s) to prevent recurrences:

Supervisor Signature	Print Name:	Date:
Superintendent Signature:	Print Name:	Date:

THIS INFORMATION MUST BE COMPLETED AND RETURNED TO THE SAFETY DEPARTMENT WITHIN 24 HOURS AFTER NOTIFICATION THAT AN INCIDENT HAS OCCURRED.

Safety Dept Signature:	Print Name:	Date:

INCIDENT REVIEW

Check the appropriate severity of the incident:

___ First Aid Only ___ Non-conformance ___ Equipment/Property Damage

___ Close call/Near Miss ___ Recordable injury ___ Illness

OSHA Log Number:

HR DEPARTMENT

Did the employee write a statement?	☐ YES	☐ NO
Did all witnesses complete statements?	☐ YES	☐ NO
Was the incident investigation filled out completely?	☐ YES	☐ NO
Were the appropriate safety and supervisory personnel involved?	☐ YES	☐ NO
Was the root cause identified?	☐ YES	☐ NO
Were immediate steps to prevent recurrence outlined?	☐ YES	☐ NO
Has corrected action been completed?	☐ YES	☐ NO
Will corrective actions prevent recurrence of the incident?	☐ YES	☐ NO
Did all responsible parties sign off on the investigation?	☐ YES	☐ NO

Was BBP clean up preformed? Who? Date of last training. ☐ YES ☐ NO Name /Date

HR Manager Signature: Date

RISK ASSESSMENT COMMITTEE

Risk Assessment Committee Members:

Probability of Event Recurring (Likelihood)?

☐ Frequent ☐ Likely ☐ Occasional ☐ Remote ☐ Improbable

Severity Potential?

☐ Catastrophic ☐ Critical ☐ Serious ☐ Marginal ☐ Unlikely

Exposure Frequency?

☐ Often ☐ Occasional ☐ Infrequent ☐ Seldom

Were risk assessments evaluated and updated? ___ YES ___ NO

If yes, list the date risk assessments were updated: _____

If no, list why risk assessments were not updated:

Risk Assessment Committee Signatures: Date: