

## DOA ACCIDENT INVESTIGATION FORM

Date of accident		Time		Location	
Classification <input type="checkbox"/> no injury <input type="checkbox"/> first aid <input type="checkbox"/> medical <input type="checkbox"/> lost time					
Injured person's name				Occupation	
Social Security No.			Immediate supervisor		
Nature of injury <input type="checkbox"/> cut <input type="checkbox"/> bruise <input type="checkbox"/> burn <input type="checkbox"/> fracture <input type="checkbox"/> other (describe):					
Part(s) of body injured <small>(also mark body chart on reverse of form)</small>			What first aid or assistance rendered at site?		
Place where injuries were treated				Did injured return to work? <input type="checkbox"/> yes <input type="checkbox"/> no	
Is this a reinjury or exacerbation of previous injury?				Previous injury date	
Had injured person received training about how to prevent this accident?				When?	
What PPE was required for task being performed?				Was it being used?	
Task being performed when accident occurred					
Describe the accident  <div style="border-bottom: 1px solid black; height: 1.2em; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 1.2em; margin-bottom: 5px;"></div>					
Property damaged			Nature of damage		
Owner of property			Estimated cost of damage \$		
Who took photos at scene?			Attached are <input type="checkbox"/> photos <input type="checkbox"/> diagrams <input type="checkbox"/> drawings		
Witness Name:		Witness statement (see reverse, if necessary)			
What could have been done to prevent this accident?  <div style="border-bottom: 1px solid black; height: 1.2em; margin-bottom: 5px;"></div>					
Describe immediate steps taken to prevent further injuries or damage  <div style="border-bottom: 1px solid black; height: 1.2em; margin-bottom: 5px;"></div>					
Describe plans to prevent similar accidents in the future  <div style="border-bottom: 1px solid black; height: 1.2em; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 1.2em; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 1.2em; margin-bottom: 5px;"></div>					
<small><input type="checkbox"/> Additional reports attached</small>					
Supervisor's name		Supervisor's signature		Date	
ESH reviewer's name		Reviewer's signature		Date	
Comments  <div style="border-bottom: 1px solid black; height: 1.2em; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 1.2em; margin-bottom: 5px;"></div>					

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