Accident description form

Use this form to document information about an accident or incident. Fill out an investigation report as soon as possible. Note: this form is for use within your company. It is not intended to replace DCBS Form 801: *Worker's and Employer's Report of Occupational Injury or Disease*.

Employee(s) name(s): .....

Time & date of accident/incident: .....

Job title(s) and department(s): .....

Supervisor or lead person: .....

Witnesses: .....

Brief description of the accident or incident: .....

.....

Body part affected: .....

Did the injured employee(s) see a doctor? ( ) Yes ( ) No

If yes, did you file an employer's portion of a worker's compensation form? ( ) Yes ( ) No

Did the injured employee(s) go home during their work shift? ( ) Yes ( ) No

If yes, list the date and time injured employee(s) left job(s): .....

Supervisor's Comments: .....

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What could have been done to prevent this accident/incident? .....

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Have the unsafe conditions been corrected? ( ) Yes ( ) No

If yes, what has been done? .....

If no, what needs to be done? .....

Employer or Supervisor's signature:

Date:

Additional comments/notes: .....

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