City of Pittsburgh
Incident Investigation Form

(Sections 1, 2 &3 to be completed by person conducting investigation) **CCR#: _____**

SECTION 1

Name of Injured: _____ Employee Number: _____

Dept./Location where injury occurred: _____ Job Assigned: _____

SECTION 2

Date of Incident: _____ Time of Incident: _____ Type of Injury: _____

Date/Time reported: _____ To Whom: _____

Specific Location of Incident: _____

Supervisor at Time of Incident: _____

SECTION 3

Describe how incident occurred (list events leading up to the incident)

List causal factors (events and conditions contributing to the incident)

CORRECTIVE ACTIONS (To be completed by Direct Supervisor)

Action Required	Responsible Party	Date Due

Investigated by: _____ Title: _____

Department: _____ Date: _____

Signature of Department Manager _____

Complete all information above and return to the Department of Human Resources & Civil Service Occupational Safety Office within 72 hours of incident.

<u>Follow-up</u> completed by representatives of the Occupational Safety Office

Action Completed	Date Completed

Follow up performed by: _____

Department: _____ Date: _____

_____ Fatality
_____ Lost Work Day/ # of Days
_____ Restricted Activity
_____ Medical Only
_____ Property Damage
_____ Near Miss

cc: Department File
Supervisor
Safety –Injury Prevention