

Incident Investigation Form

Last Name:	First Name:	Occupation/Job Title:	Yrs. Experience in Occupation:
Full Address:			
City/Town:			Postal Code:
Division/Branch:		Date of Occurance:	Time:
Location:		Date Reported:	Time:
<input type="checkbox"/> Hazardous Situation <input type="checkbox"/> Incident <input type="checkbox"/> First Aid <input type="checkbox"/> Health Care <input type="checkbox"/> Lost-Time <input type="checkbox"/> Critical Injury			
Describe what happened and, if applicable, describe injury. Attach an accident/incident diagram, if appropriate.			
Describe the nature, date, and time of first aid treatment, if applicable.			
Signature of person reporting incident:			

Part of Body Injured *(Indicate "R", "L", or "B", where applicable)*

<input type="checkbox"/> Head	<input type="checkbox"/> Lower back	<input type="checkbox"/> Hand/fingers	<input type="checkbox"/> Ankle/foot
<input type="checkbox"/> Eye	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Hip	<input type="checkbox"/> Other
<input type="checkbox"/> Neck	<input type="checkbox"/> Elbow	<input type="checkbox"/> Upper leg	
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Lower Arm	<input type="checkbox"/> Knee	
<input type="checkbox"/> Upper back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Lower leg	

Type of Accident/Incident

Check off (✓) statements that best describe the accident/incident:

<input type="checkbox"/> Repetitive Strain	<input type="checkbox"/> Slip/fall	<input type="checkbox"/> Exposure to
<input type="checkbox"/> Acute Strain (lifting, pulling, carrying)	<input type="checkbox"/> Vehicle	<input type="checkbox"/> Other (explain)
<input type="checkbox"/> Caught in/under/between	<input type="checkbox"/> Client/employee action	
<input type="checkbox"/> Struck, contacted by/with/against	<input type="checkbox"/> Cut/bruise	

Witnesses

Name:	Telephone:
Address:	
Name:	Telephone:
Address:	
Physician's Name:	Telephone:
Address:	
Remember to attach witness(es) statement(s).	

Causes (Check (✓) all that are applicable)

<p>Conditions:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Congestion or restricted action <input type="checkbox"/> Poor housekeeping; disorderly workplace <input type="checkbox"/> Slip/trip hazards <input type="checkbox"/> Lack of or inappropriate furniture/equipment <input type="checkbox"/> Design or arrangement of furniture/equipment <input type="checkbox"/> Defective furniture, tools, equipment, or materials <input type="checkbox"/> Inadequate or excessive illumination <input type="checkbox"/> Inadequate ventilation <input type="checkbox"/> Excessive noise <input type="checkbox"/> Inadequate or improper protective equipment <input type="checkbox"/> Fire and explosion hazards <input type="checkbox"/> Inadequate warning systems <input type="checkbox"/> Irrate client/employee action <input type="checkbox"/> Adverse weather <input type="checkbox"/> Other (explain): _____ 	<p>Practices:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Improper body position/posture <input type="checkbox"/> Tasks not varied/micro breaks not taken <input type="checkbox"/> Unnecessary rushing <input type="checkbox"/> Improper lifting <input type="checkbox"/> Unsafe loading/placement <input type="checkbox"/> Using defective equipment <input type="checkbox"/> Using equipment improperly <input type="checkbox"/> Altering or modifying equipment <input type="checkbox"/> Not using personal protective equipment or failing to use it properly <input type="checkbox"/> Not following appropriate procedures <input type="checkbox"/> Inappropriate conduct <input type="checkbox"/> Hazardous personal attire <input type="checkbox"/> Other (explain): _____
<p>What are the reasons for these practices and/or conditions?</p>	

Prevention/Corrective Action

<p><i>Check (✓) actions taken to prevent recurrence. Mark with (P) corrective actions planned but not yet carried out.</i></p>	
<ul style="list-style-type: none"> <input type="checkbox"/> Training/instruction of person involved <input type="checkbox"/> Improve work procedures <input type="checkbox"/> Inform staff/managers of safe work procedures <input type="checkbox"/> Perform job safety analysis <input type="checkbox"/> Inform staff/managers of hazard and how to protect themselves <input type="checkbox"/> Notify appropriate individuals <input type="checkbox"/> Improve engineering/design <input type="checkbox"/> Improve inspection procedures <input type="checkbox"/> Tools, equipment, furniture repair or replacement 	<ul style="list-style-type: none"> <input type="checkbox"/> Request ergonomic assessment <input type="checkbox"/> Request environmental assessment <input type="checkbox"/> Correction of work area <input type="checkbox"/> Recommend development/improvement to training/OH&S program <input type="checkbox"/> Reassess work standards <input type="checkbox"/> Reassignment of person <input type="checkbox"/> Improve housekeeping <input type="checkbox"/> Other: _____
<p>Describe actions taken.</p>	

Investigated by:		
Manager's Signature:	Name (print):	Date:
Reviewed by:		
Signature:	Name (print):	Date:



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