INCIDENT INVESTIGATION PRELIMINARY REPORT / OSHA 301

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date: |   | Department: |  | Manager: |  |  |

**This form is to be completed for ALL incidents/accidents and must be** emailed **to**

**Office / Company Representative within 24 hours**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Employee Name
 |        | Co-Policy ID#:  |         |
|  Employee Home Address |       |
|  2. Work Shift |  [ ]  1 [ ]  2 [ ]  3 |  Call Back |  [ ]  Yes [ ]  No |  Overtime | [ ]  Yes [ ]  No |
|  3. Length of Service – Company | [ ]  <1 [ ]  1-4 [ ]  5-10 [ ]  10-20 [ ]  20-30 [ ]  >30 | Hire Date |       |
|  Length of Service – Industry  |  [ ]  <1 [ ]  1-4 [ ]  5-10 [ ]  10-20 [ ]  20-30 [ ]  >30 | Hire Date |       |
| Employee’s Age |    | [ ]  Male [ ]  Female Tel#:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  Social Security #: |       Date of Birth:        |
|  4. Employee’s Dept | Choose an item. | Product Type | Choose an item. |
|  Job Title |       | Employee Type | Choose an item. |
|  5. Incident Date |       | Time |       | [ ]  AM [ ]  PM | Date Reported |       |
|  6. Investigated by:       |  |
|  Employee’s Manager |       |
|  7. Was an on-site investigation performed?  | [ ]  Yes [ ]  No |  Date Investigated |       |
|  8. Was there a JHA completed for the task?  | [ ]  Yes [ ]  No |  Date Completed |       |
|  9. Witnesses |       |
| 10. Building Name |       |
|  Street Address |       City/State:        |
| 11. Location site |       |
|  | (hoistway, machine room, car top, pit, warehouse, factory, auto, office, lobby, escalator, other) |
| 12. Incident Description |       |
| 13. Activity Performing |       |
| 14. Drug Test - Ref. Co. Policy |  [ ]  Yes [ ]  No |  Date Completed |       |
|  HIPAA Form Complete?  |  [ ]  Yes [ ]  No |  Date Completed |       |
| 15. Citation(s) Issued [ ]  Yes (If yes, attach copy) | [ ]  No (If no, explanation required) |
|       |
| 16. Personal Protective Equipment Required | [ ]  Yes [ ]  No |
| If yes, what  |       |
|  Was the equipment used or worn? | [ ]  Yes [ ]  No |
| 17. If Laceration Were Gloves Worn? | [ ]  Yes [ ]  No [ ]  NA  | Type: | Choose an item. |
| 18. Third Party Involvement (Contractor) | [ ]  Yes [ ]  No | Who? |       |
| 19. Hospital / Treating Physician’s Name and Address |       |
|       |
| 20. Type of Case? | [ ]  First Aid [ ]  OSHA (Stitches, Lost Time, Light Duty) - [ ]  Just Reported Incident |
| 21. Severity of Injury | Choose an item. |  |  |
|  *\* Type of Medical Treatment / First Aid Provided (must be completed):* |       |
| 22. Has the Employee returned to work?  | [ ]  Yes [ ]  No | Return Date: TBD  |       |
| 23. Number of lost workdays |      | (Must track days until employee returns) |
| 24. Number of restricted duty workdays |      | Track until RTW Full Duty |
| 25. Has the Company insurance been notified? [ ]  Yes [ ]  No |  |
| 26. Completing the following task?  | Choose an item. |
| 27. As a result of the following: | Choose an item.   |
| 28. Body part  | Choose an item.      |
| 29. Type of injury that occurred: | Choose an item. |
| 30. The direct cause(s) are: |  |
|  Conditions | Choose an item. |
|  Procedures | Choose an item. |

 Additional Contributing Factors: Note: this is the statement from the injured employee and those who may have
 Witnessed the incident.

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|       |
| 31. The root causes are (ONLY select causes that apply): |  |
|  Hazard Recognition | Choose an item. |
|  Control Measures | Choose an item. |
|  Training | Choose an item. |
|  Communications | Choose an item. |
|  Policy, Rules, Procedures | Choose an item. |
|  Inspections/Assessments | Choose an item. |
|  Motivation | Choose an item. |
|  |  |

32. Corrective Action (Corrective action must be in place for all root causes identified):

|  |  |  |
| --- | --- | --- |
| *ACTION* | *RESPONSIBILITY* | *TIMING* |
|       |       |       |
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Internal Distribution: All correspondence will be emailed in compliance with company policy and reviewed within 24 hours.

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| * Co. President
 |  |
| * Co. Operations
 |  |
| * Co. Dept Head
 |  |
| * Safety Dept.
 |  |