INCIDENT INVESTIGATION PRELIMINARY REPORT / OSHA 301

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

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

**Office / Company Representative within 24 hours**

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

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| *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. | |  | | |