

Appendix B

Van Buren County, AR ACCIDENT/INCIDENT INVESTIGATION FORM

Near Miss \_\_\_ First Aid Req. \_\_\_ Medical Req. \_\_\_ ADOL Recordable \_\_\_ FAXED to AAC \_\_\_\_\_ 501-375-8671  
\*\*\*\*\*

Employer: \_\_\_\_\_ Date of this Report: \_\_\_\_\_

Injured Employee: \_\_\_\_\_ Age: \_\_\_\_\_

Department: \_\_\_\_\_ Job Title: \_\_\_\_\_

Date of Injury/Incident: \_\_\_\_\_ Time: \_\_\_\_\_ AM: \_\_\_ PM: \_\_\_

Where Injury/Incident Happened: \_\_\_\_\_

Nature of Injury/Incident/Property Damage: \_\_\_\_\_

Object/Equipment that was involved (if applicable): \_\_\_\_\_

Describe what happened: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Witness(es) Name and contact info: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Was the report to supervisor or First Aid delayed? \_\_\_ If so Why?: \_\_\_\_\_

Was Medical treatment provided? \_\_\_ Was hospitalization required? \_\_\_ By whom? \_\_\_\_\_

Where?: \_\_\_\_\_ / \_\_\_\_\_

What corrective actions are being taken to prevent reoccurrence of this type accident?: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who is responsible for completion of these actions?: \_\_\_\_\_

Employee (signature): \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor/Investigator (signature): \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by (signature): \_\_\_\_\_ Date: \_\_\_\_\_