


DOCUMENT NUMBER: QMS100203	TITLE: Incident/Injury Analysis Investigation Form	
REVISION: 1	DOCUMENT CLASSIFICATION: 03-Form, Template or Other	

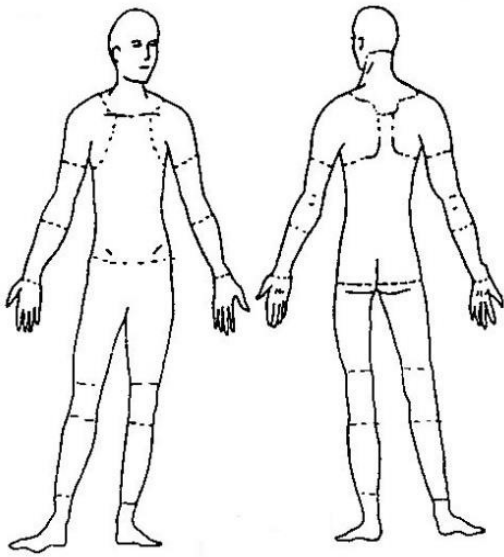
Incident/Injury Analysis Investigation Form

Incident Type: Near Miss Illness First Aid Injury Accident Death Other: _____
Date of Incident: _____ **Time of Incident:** _____ **Date of Report:** _____
Report Prepared by: Employee Supervisor Contractor Other: _____

I. Employee Data:


Name: _____ Job Title: _____ Unit: _____
Department: _____ Site: _____ Event Location: _____

II. Incident/Accident Data:

<p>A. Part of body affected (Shade all that apply):</p> <div style="display: flex; justify-content: space-around; align-items: center;">  </div> <p><input type="checkbox"/> N/A</p>	<p>B. Nature of injury</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Abrasion/Scrape</td> <td><input type="checkbox"/> Crushing Injury</td> </tr> <tr> <td><input type="checkbox"/> Amputation</td> <td><input type="checkbox"/> Cut/Laceration/Puncture</td> </tr> <tr> <td><input type="checkbox"/> Broken Bone</td> <td><input type="checkbox"/> Skin Irritation</td> </tr> <tr> <td><input type="checkbox"/> Bruise</td> <td><input type="checkbox"/> Hernia</td> </tr> <tr> <td><input type="checkbox"/> Burn (heat/cold)</td> <td><input type="checkbox"/> Illness</td> </tr> <tr> <td><input type="checkbox"/> Burn (chemical)</td> <td><input type="checkbox"/> Sprain/Strain</td> </tr> <tr> <td><input type="checkbox"/> Concussion/Head Injury</td> <td><input type="checkbox"/> Damage to Body System</td> </tr> <tr> <td><input type="checkbox"/> Chemical Exposure</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> N/A</td> </tr> </table> <p>C. This employee works:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Regular Full Time</td> <td><input type="checkbox"/> Seasonal</td> </tr> <tr> <td><input type="checkbox"/> Regular Part Time</td> <td><input type="checkbox"/> Temporary</td> </tr> </table> <p>Tenure with company: _____ Months Doing this Job: _____</p> <p align="center">If Not Applicable for both II.A. and II.B proceed to question 1 (page 2)</p>	<input type="checkbox"/> Abrasion/Scrape	<input type="checkbox"/> Crushing Injury	<input type="checkbox"/> Amputation	<input type="checkbox"/> Cut/Laceration/Puncture	<input type="checkbox"/> Broken Bone	<input type="checkbox"/> Skin Irritation	<input type="checkbox"/> Bruise	<input type="checkbox"/> Hernia	<input type="checkbox"/> Burn (heat/cold)	<input type="checkbox"/> Illness	<input type="checkbox"/> Burn (chemical)	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Concussion/Head Injury	<input type="checkbox"/> Damage to Body System	<input type="checkbox"/> Chemical Exposure	<input type="checkbox"/> Other: _____		<input type="checkbox"/> N/A	<input type="checkbox"/> Regular Full Time	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Regular Part Time	<input type="checkbox"/> Temporary
<input type="checkbox"/> Abrasion/Scrape	<input type="checkbox"/> Crushing Injury																						
<input type="checkbox"/> Amputation	<input type="checkbox"/> Cut/Laceration/Puncture																						
<input type="checkbox"/> Broken Bone	<input type="checkbox"/> Skin Irritation																						
<input type="checkbox"/> Bruise	<input type="checkbox"/> Hernia																						
<input type="checkbox"/> Burn (heat/cold)	<input type="checkbox"/> Illness																						
<input type="checkbox"/> Burn (chemical)	<input type="checkbox"/> Sprain/Strain																						
<input type="checkbox"/> Concussion/Head Injury	<input type="checkbox"/> Damage to Body System																						
<input type="checkbox"/> Chemical Exposure	<input type="checkbox"/> Other: _____																						
	<input type="checkbox"/> N/A																						
<input type="checkbox"/> Regular Full Time	<input type="checkbox"/> Seasonal																						
<input type="checkbox"/> Regular Part Time	<input type="checkbox"/> Temporary																						

Only answer II.D. and II.E. for chemical exposure and illness events

<p>II.D. Chemical Exposure Symptoms</p> <ul style="list-style-type: none"> <input type="checkbox"/> Eye irritation, teary eyes, or blurred vision <input type="checkbox"/> Respiratory irritation or shortness of breath <input type="checkbox"/> Disorientation or becoming uncoordinated <input type="checkbox"/> Nausea or feeling nauseated <input type="checkbox"/> Runny nose or excessive salivation <input type="checkbox"/> Burning nose or throat <input type="checkbox"/> Sudden headache <input type="checkbox"/> Sudden sweating <input type="checkbox"/> Stomach aches 	<p>II.E. Illness Symptoms</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> New loss of taste or smell</td> <td><input type="checkbox"/> Fever</td> </tr> <tr> <td><input type="checkbox"/> Congestion or runny nose</td> <td><input type="checkbox"/> Cough</td> </tr> <tr> <td><input type="checkbox"/> Nausea or vomiting</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Muscle or body aches</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Headache</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Diarrhoea</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Shortness of breath or difficulty breathing</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Sore throat</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Fatigue</td> <td></td> </tr> </table>	<input type="checkbox"/> New loss of taste or smell	<input type="checkbox"/> Fever	<input type="checkbox"/> Congestion or runny nose	<input type="checkbox"/> Cough	<input type="checkbox"/> Nausea or vomiting		<input type="checkbox"/> Muscle or body aches		<input type="checkbox"/> Headache		<input type="checkbox"/> Diarrhoea		<input type="checkbox"/> Shortness of breath or difficulty breathing		<input type="checkbox"/> Sore throat		<input type="checkbox"/> Fatigue	
<input type="checkbox"/> New loss of taste or smell	<input type="checkbox"/> Fever																		
<input type="checkbox"/> Congestion or runny nose	<input type="checkbox"/> Cough																		
<input type="checkbox"/> Nausea or vomiting																			
<input type="checkbox"/> Muscle or body aches																			
<input type="checkbox"/> Headache																			
<input type="checkbox"/> Diarrhoea																			
<input type="checkbox"/> Shortness of breath or difficulty breathing																			
<input type="checkbox"/> Sore throat																			
<input type="checkbox"/> Fatigue																			

DOCUMENT NUMBER: QMS100203	TITLE: Incident/Injury Analysis Investigation Form	
REVISION: 1	DOCUMENT CLASSIFICATION: 03-Form, Template or Other	

1. Where did the incident/accident/near miss occur? (Describe exact location)

1.a. If incident occurred at customer site, please provide the following information:

Client: _____
 Client Address: _____
 Name of client's EHS officer: _____
 EHS Office contact information _____

1.b. What part of employee's workday did the incident occur:

- Entering or leaving work
- During normal work activities
- During break
- While working overtime

2. What was the employee doing when the incident/accident/near miss occurred? (Fully describe the events which led to the incident)


2.a. Was the activity being performed part of the employee's regular work routine? Yes No Unknown N/A

2.b. Did the employee receive training to perform the activity?
 Yes No Unknown N/A

2.c. Were established procedures being followed at the time of incident? Yes No Unknown N/A

3. How did the incident/accident/near miss occur? (Fully describe the events that caused the incident/accident)

4. Describe any object or substance involved in the incident/accident/near miss.

DOCUMENT NUMBER: QMS100203	TITLE: Incident/Injury Analysis Investigation Form	
REVISION: 1	DOCUMENT CLASSIFICATION: 03-Form, Template or Other	

5. Witness to the incident: (list of names)

6. Did a foreign body (needle, glass, shard, splinter, etc.) penetrate the employee's body?

- Yes (if yes, what was the object? Include type and brand) _____
 No

7. Was any fluid injected into the employee's body? Yes No

If yes, what fluid? _____

8. Was this a splash incident? Yes No

If yes, did it involve eye exposure? Yes No

III. Initial Treatment


- No Medical Treatment
 Minor Treatment/First Aid
 Hospital/A&E
 Hospitalization for more than 24 hours
 Other: _____

I CERTIFY THAT THE INCIDENT DATA ABOVE IS TRUE

Employee Name

Employee Signature

Date

DOCUMENT NUMBER: QMS100203	TITLE: Incident/Injury Analysis Investigation Form	
REVISION: 1	DOCUMENT CLASSIFICATION: 03-Form, Template or Other	


IV. Root Cause Analysis - 5 Why's (To be completed by HSEQ and Supervisor)

CAUSE 1	Why? ▼	Why? ▼	Why? ▼	Why? ▼	Why? ▼	Root Cause
Why is "A" causing a gap of ?						
Gemba Evidence:						
CAUSE 2	Why? ▼	Why? ▼	Why? ▼	Why? ▼	Why? ▼	Root Cause
Why is "B" causing a gap of ?						
Gemba Evidence:						
CAUSE 3	Why? ▼	Why? ▼	Why? ▼	Why? ▼	Why? ▼	Root Cause
Why is "C" causing a gap of ?						
Gemba Evidence:						

IV. A. Analysis of Factors (To be completed by HSEQ Manager)

<p>Potentially Unsafe Conditions (Check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Poor Housekeeping <input type="checkbox"/> Slippery Conditions <input type="checkbox"/> Unguarded Hazard <input type="checkbox"/> Safety Device Damaged or Defective <input type="checkbox"/> Tool or Equipment Damaged or Defective <input type="checkbox"/> Workstation Layout <input type="checkbox"/> Inadequate Lighting <input type="checkbox"/> Inadequate Ventilation <input type="checkbox"/> Lack of Personal Protective Equipment <input type="checkbox"/> Lack of Appropriate Equipment or Tools <input type="checkbox"/> Unsafe Clothing <input type="checkbox"/> Insufficient Training <input type="checkbox"/> Inadequate Supervision <input type="checkbox"/> Other: _____ 	<p>Unsafe Acts (Check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Failure to follow established procedures <input type="checkbox"/> Performing action without training <input type="checkbox"/> Operating without permission <input type="checkbox"/> Operating at an unsafe speed or pace <input type="checkbox"/> Servicing live equipment <input type="checkbox"/> Disabling a safety device <input type="checkbox"/> Using defective equipment <input type="checkbox"/> Using equipment in an unapproved way <input type="checkbox"/> Unsafe lifting <input type="checkbox"/> Distraction, teasing, or horseplay <input type="checkbox"/> Failure to wear personal protective equipment <input type="checkbox"/> Failure to use the available equipment or tools <input type="checkbox"/> Putting self in the "line of fire" <input type="checkbox"/> Other: _____
--	--

Were the unsafe acts and/or conditions reported to management prior to the incident? Yes No
 Have there been similar incidents or near misses prior to this case? Yes No

DOCUMENT NUMBER: QMS100203	TITLE: Incident/Injury Analysis Investigation Form	
REVISION: 1	DOCUMENT CLASSIFICATION: 03-Form, Template or Other	

V. Incident Prevention/Corrective Measures (To be completed by HSEQ Manager)

What changes do you suggest to prevent this incident/near miss from happening again?

<input type="checkbox"/> Stop this activity	<input type="checkbox"/> Redesign task steps	<input type="checkbox"/> Routinely inspect for the hazard
<input type="checkbox"/> Guard the hazard	<input type="checkbox"/> Redesign workstation	<input type="checkbox"/> Implement additional PPE
<input type="checkbox"/> Train the employee(s)	<input type="checkbox"/> Revise/create policy/rule	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Improve Supervision	<input type="checkbox"/> Enforce existing policy	

What should be (or has been) done to carry out the suggestion(s) checked above and/or resolution?

I CERTIFY THAT THE INCIDENT INVESTIGATION IS COMPLETE AND CORRECTIVE MEASURES WILL BE IN PLACE

_____	_____	_____
Supervisor Name	Signature	Date

_____	_____	_____
HSEQ Manager Name	Signature	Date

DIRECTOR ACKNOWLEDGEMENT OF REPORT

_____	_____	_____
Director Name	Signature	Date