Print Form

For Police Department Employees Only:	
RB#:	CR#:

Investigation Report for Occupational Injury or Illness

E	Name:		SSN:
M	Department:		Division:
P	Job Classification:		Work Phone #:
L	Name of Immediate Supervisor:		Supervisor Phone #:
O	Date of Injury:	Time of Injury:	
Y	Did you report the accident/injury:	To Whom:	
E	When Reported:	Where did injury occur:	
E	Describe the injury or illness in detail and indicate the part of the body affected (i.e. amputation or right index finger at second joint).		
	How did the accident/injury occur?		
	Date and location of initial treatment:		

The following questions are to help analyze the accident and determine the cause (s) of the accident (why did the accident occur?) and the action (s) taken to insure this kind of accident does not occur again (how can this kind of accident be avoided?) These questions are asked for internal disciplinary and safety reasons only, and not for the purpose of any determination of legal liability. If you need additional space for your answers, please add an additional page.

	In the future, what could the employee do differently in this type of situation to make such an accident less likely to occur?	
S	What other persons, or factors beyond the employee's control, contributed to the accident? How did these other persons or factors contribute to the accident?	
U		
P		
E	What corrective action has been or will be taken to prevent a similar accident?	
R		
V	What documents, conversations, or personal observations served as your sources of information regarding how this accident occurred?	
I		
S		
O	What personal protective equipment was required for the job being done?	
R		
	Was the injured employee wearing or using the necessary equipment described above? If not, why?	

If there are witnesses have individual (s) complete witness statement on page 2.

W	Name of witness (#1):	
I		
T	Work Phone #:	Home Phone #:
N		
E	Name of witness (#2):	
S		
S	Work Phone #:	Home Phone #:

I have read this report and, to the best of my knowledge, the facts as presented above are correct.

Employee Signature:		Date:
Supervisor Signature:		Date:

Updated: 9/10/2010

Page 2 - Statement of Witness to Accident (to be completed by each witness)

Name of Witness: _____
Last Name First Name Middle Initial

Date Statement Taken: _____ Employer: _____

Name of Injured: _____
Last Name First Name Middle Initial

Name of person taking this statement: _____

Describe in your own words how the accident occurred: (Witness' statement)

I attest this statement is true and factual to the best of my knowledge.

Signature of witness to accident: _____

Date signed: _____

Signature witnessed by: _____