ACCIDENT/INVESTIGATION/NEAR-MISS INVESTIGATION REPORT

This form is to be used to document supervisory investigations of work-related accidents & incidents that result in injury as mandated by CCR T8 §3203 (a)(5). This report should also be used to document investigation of "near-miss" incidents that could have resulted in injury/illness.

Employee's Name: Job Title:

Hire Date: Position Date: Agency/Dept. Name/BU#:

Supervisor's Name: Title: Phone #:

Date & Time of Incident: Incident Report Date: Date Investigation Completed:
Date Investigation Began:

Person Conducting the Investigation; If other than the supervisor: (Include job title and phone number).

Incident Location: (Also complete drawing or diagram on the bottom of page 2).

Incident Type: (Select all that apply)

- ☐ Struck Against
- ☐ Struck By
- ☐ Caught In or Between
- ☐ Fall on Same Level
- ☐ Fall to Different Level
- ☐ Lift or Twist
- ☐ Muscular Strain
- ☐ Training (Lack of)
- ☐ RMI (office)
- ☐ RMI (non-office) (Repetitive Motion Injury)
- ☐ Skin Exposure
- ☐ Exposure to Temp. Extreme
- ☐ Respiratory Exposure
- ☐ Contact Electrical Current
- ☐ Exposure to Physical Agents (Noise/Radiation/Chemical)
- ☐ Foreign Object to eye (R/L)
- ☐ Other (Describe)

Incident Description: (What happened, **Be specific**)

Injury/Illness Description: (**Be specific** i.e., 1" cut to third finger, left hand, etc.)

Property Damage Description:

Root Cause: (Select all that apply)

- ☐ Procedures
- ☐ Environment
- ☐ Training
- ☐ Communication
- ☐ Facilities
- ☐ In a Hurry
- ☐ Equipment
- ☐ Other: (Describe)

Describe Primary Cause of Incident:

Additional Causes: (If any)

DISTRIBUTION: Risk Management, Agency/Department Head, Supervisor, Employee

Fax (805)648-9238 – Email address: risk.management@ventura.org

Assessment of Future Severity Potential:
☐ Major – Likely to cause permanent disability, loss of life, body part and/or extensive property damage.
☐ Serious – Likely to cause temporary disability or disruptive property damage.
☐ Minor – Likely to cause non-disabling injury or non-disruptive property damage.

Assessment of Probability of Incident Recurring: ☐ Frequent ☐ Occasional ☐ Rare

Other Relevant Incident/Employee Information:

Names of witnesses: (If any) 1 Phone #: 1
2 2
3 3

Was employee qualified and familiar with processes/equipment/machinery? ☐ Yes ☐ No ☐ N/A
Were there other people working on the job at the time of Incident? ☐ Yes ☐ No ☐ N/A
Was employee trained in hazards specific to this type of injury? ☐ Yes ☐ No ☐ N/A
Were proper tools/equipment/procedures being used and/or followed? ☐ Yes ☐ No ☐ N/A
Was employee properly supervised? ☐ Yes ☐ No ☐ N/A
Was the equipment in serviceable condition at the time of Incident? ☐ Yes ☐ No ☐ N/A
When was the last equipment inspection date? Provide date:
What were the working and/or environmental conditions at the time of Incident?

Corrective Action:
Was the unsafe condition, practice, equipment, or protective equipment problem corrected immediately? ☐ Yes ☐ No ☐ N/A
If no, what has been done to assure correction?

Until corrected, what actions have been taken to prevent recurrence in the interim?

Will inspection checklists, procedures, and/or training have to be modified to prevent recurrence? ☐ Yes ☐ No
If yes, what will be changed and how will employees be notified?

Person Responsible for Corrective Action:

Title: Department: Phone #:

Targeted Corrective Action Completion Date: Actual Corrective Action Completion Date:

Please draw diagram below if beneficial to explain incident. (You can also attach your own drawing).