UH | WalkSafe

Employee Accident Investigation Report with Slip, Trip and Fall Supplement

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UH UnitedHeartland

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Name:_______________________________________ Program/Job Title: ____________________________

Accident Occur on Agency Premises: ☐Yes ☐ No Accident Location: ____________________________

Date of Injury: ______________________________ Time:___________________________ ☐ am ☐ pm

Sex: ☐ F ☐ M

Date Reported: ______________________________ Witnesses: ____________________________________

Accident Description: ____

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Injured Area	Indicate Area of Injury	Type of Injury
1 ☐ Head		1 ☐ Abrasion
2 ☐ Eye: L / R		2 ☐ Amputation
3 ☐ Shoulder: L/R		3 ☐ Bite: ________
4 ☐ Arm: L/R	Neck	4 ☐ Bruise
5 ☐ Elbow: L / R	Arm Shoulder	5 ☐ Burn
6 ☐ Wrist: L / R		6 ☐ Concussion
7 ☐ Hand: L / R	Upper Back	7 ☐ Cut / Laceration
8 ☐ Finger:	Wrist	8 ☐ Foreign Body
Specify_____________	Hand Elbow	9 ☐ Fracture
9 ☐ Back		10 ☐ Hearing Impaired
10 ☐ Chest	Lower Back	11 ☐ Infection
11 ☐ Abdomen		12 ☐ Pain: __________
12 ☐ Pelvis		13 ☐ Puncture
13 ☐ Hip L / R	Hip/Thigh	14 ☐ Rash/Dermatitis
14 ☐ Leg: L / R		15 ☐ Respiratory
15 ☐ Knee: L / R		16 ☐ Strain/Sprain
16 ☐ Ankle: L / R	Lower Leg	17 ☐ Other: ______
17 ☐ Foot: L / R		_________________
18 ☐ Toe:	Foot	
Specify ____________		
19 ☐ Other: _____	LEFT RIGHT	

Did injured employee miss work? ☐ Yes ☐ No Dates:____

Form Completed by:_____________________________________Date:____

Supervisor's Signature:____ Date: ______________________

Program Director's Signature: ___________________________________ Date: ______________________

Investigation Report

Cause of Accident	Source
	1 ☐ Bitten by: Human/Animal
	2 ☐ Caught Between/In/On
	3 ☐ Contact by or with Chemical/Electricity/Other
	4 ☐ Equipment Involved:____________________
	5 ☐ Exposure to ________________________
	6 ☐ Fall/Slip/Trip :_______________________
	7 ☐ Falling/Flying Object
	8 ☐ Handling Materials
	9 ☐ Standing on: Ladder/Step Stool/Chair
	10 ☐ Struck by: _________________________
	11 ☐ Vehicle Accident: _____________________
	12 ☐ Other:____________________________

Corrective Action	Action Taken
____________________	1 ☐ House Keeping Improved
____________________	2 ☐ Office Arrangement Changed
____________________	3 ☐ Safety Equipment Purchased
____________________	4 ☐ Replace Furniture or Equipment
____________________	5 ☐ Training for Employee
____________________	6 ☐ Maintenance & Upkeep Plan
____________________	7 ☐ Safety Committee Referral
____________________	8 ☐ Other ____________________
____________________	9 ☐ Other ____________________
____________________	10 ☐ Other ____________________
____________________	11 ☐ Other ____________________
____________________	
____________________	
____________________	
____________________	
____________________	

Person responsible for corrective actions: ____________________________Target completion date:___________

Signature of person responsible for corrective actions: ____

Date corrective actions completed:___________________________ Additional follow up needed? ☐ Yes ☐ No

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Slip, Trip, Fall Supplement: ADDITIONAL INFORMATION TO BE COMPLETED FOR ALL STF INJURIES

Provide a description of what happened (outline key facts of the STF event): ______________________________

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Consider the following items and document any that may have been contributing factors to the event:

What job task or activity was the employee performing at the time of the incident:________________________

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Location of the STF Incident: ____

Snow/Ice Accumulation: ____

Other Contaminants/Items on Walking Surface: ____

Type or Condition of Footwear: ____

Type or Condition of Walking Surface/Flooring Material: ____

Housekeeping Issues: (Spill Cleanup Procedures, Wet Floor Signs Available, etc) ______________________

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Entry Mats/Rugs: ____

Adequacy of Lighting in Area: ____

Equipment/Tools being used: ____

Other Contributing Factors: ____

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STF Analysis and Follow Up:

Location of the STF Incident: ______________________________

Snow/Ice Accumulation: ______________________________

Other Contaminants/Items on Walking Surface: ______________________________

Type or Condition of Footwear: ______________________________

Type or Condition of Walking Surface/Flooring Material: ______________________________

Housekeeping Issues: (Spill Cleanup Procedures, Wet Floor Signs Available, etc) ______________________________

____

Entry Mats/Rugs: ______________________________

Adequacy of Lighting in Area: ______________________________

Equipment/Tools being used: ______________________________

Other Contributing Factors: ______________________________

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Cause Analysis: Based on the review of facts and gathering of information, what are the underlying causes(s) that largely contributed to the incident? ______________________________

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Trend Data Analysis: In review of other sources of data such as work comp loss runs, OSHA logs and injury reports, describe any trends that may exist between other similar STF injuries. ______________________________

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Injured Employee: Has the injured worker had a previous fall? ______________________________

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Prevention: What actions need to be taken to prevent reoccurence of similar STF incidents? ______________

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Safety Team: Has the incident report been submitted to a Safety Team or Committee for review?

____

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Summarize Corrective Actions Taken:	Steps of Investigation Completed
______________________________	1 ☐ Injured employee interviewed
______________________________	2 ☐ Coworkers and witnesses interviewed
______________________________	3 ☐ Site of STF incident toured
______________________________	4 ☐ Photos taken
______________________________	5 ☐ Accident investigation report completed
______________________________	6 ☐ Cause analysis completed
______________________________	7 ☐ Trend analysis completed
______________________________	8 ☐ Corrective actions documented and submitted
______________________________	9 ☐ Responsible parties contacted
______________________________	10 ☐ Corrective actions implemented
______________________________	11 ☐ Other :______________________________
______________________________	______________________________

Person responsible for corrective actions: ____________________________ Target completion date: __________

Signature of person responsible for corrective actions:____

Date corrective actions completed:___________________________________

Additional follow up needed? ☐Yes ☐No

Founded in 1912, AF Group (Lansing, Mich.) and its subsidiaries are a premier provider of innovative insurance solutions. Rated "A-" (Excellent) by A.M. Best,
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