

Lost Time Injury Investigation Report

Witness Statement **Injured Statement**

Investigator:		Date of Injury:	Time of Injury: am pm	
Date of Investigation:		Name/s and titles of Injured:		
Name/s titles of participants:				
Name/s titles of Witness/s				
Location of Incident:			Equipment:	
Job:				
Task at hand:				
Conditions (employees/weather):				
Type of Injury/s: <input type="checkbox"/> Strain/Sprain/ Overexertion <input type="checkbox"/> Caught on, in, between <input type="checkbox"/> Exposure to Temperature Extremes <input type="checkbox"/> Inhalation <input type="checkbox"/> Struck by <input type="checkbox"/> Slip/Trip/Fall –same level <input type="checkbox"/> Contact with Electrical current <input type="checkbox"/> Exposure to Dust, Mists <input type="checkbox"/> Absorption <input type="checkbox"/> Struck Against <input type="checkbox"/> Slip/Trip/Fall - different level <input type="checkbox"/> Burns –Chemical or Heat <input type="checkbox"/> Bite/Sting <input type="checkbox"/> Ingestion (swallowed)				
Has task been performed before: YES NO	How Often:	Hazard Assessment: YES NO	Written Job Orders: YES NO	Written Procedures: YES NO
Special Instructions: YES NO				
Job Briefing: YES NO	Formal Training: YES NO if yes, when:		PPE; Barricades, etc. in place: YES NO	
Hazards noted:				
<u>Reverse sequence of events</u>				
Injury:				
Incident/Accident:				
Preceding event 1:				
Preceding event 2:				

Investigator Signature: _____

Employee Signature: _____

Injury Investigation Summary

The incident as reported during the investigation: Date of Incident: _____; Date of Investigation: _____.

Incident analysis:

Recommendations:

Safety Coordinator Signature: _____ Date: _____

Director Signature: _____ Date: _____