

**CITY OF GEORGETOWN  
ACCIDENT/NEAR MISS REPORT and INVESTIGATION FORM**

**SECTION A: TO BE COMPLETED BY PERSON INVOLVED (or by supervisor if worker is incapacitated) AND BY THEIR SUPERVISORS.**

This form is to be used to report all accidents, or near misses, whether an injury occurred or not, and to document the investigation into the accidents by the supervisor of the person involved.

**Please complete within 24 hours of the accident. If the accident caused, or could have caused, serious injury or property damage, please contact the city safety coordinator.**

**PERSON INVOLVED IN ACCIDENT/INCIDENT (Please print) Date of this Report / /**

Title:	Last Name:	First Name:	Date of Birth:
(please check) Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Visitor/Other <input type="checkbox"/>			Male <input type="checkbox"/> Female <input type="checkbox"/>
Department:		Supervisor:	Years in position:

**DETAILS OF THE ACCIDENT**

Date: / / Time: am/pm

Location (please print): \_\_\_\_\_

Incident reported to: \_\_\_\_\_ Position: \_\_\_\_\_ Date: / /

**Part of body**

Head	Trunk	Internal	Arm	Hand	Leg	Foot
<input type="checkbox"/> eye	<input type="checkbox"/> neck	<input type="checkbox"/> heart	<input type="checkbox"/> left	<input type="checkbox"/> left	<input type="checkbox"/> left	<input type="checkbox"/> left
<input type="checkbox"/> ear	<input type="checkbox"/> hip	<input type="checkbox"/> lungs	<input type="checkbox"/> right	<input type="checkbox"/> right	<input type="checkbox"/> right	<input type="checkbox"/> right
<input type="checkbox"/> nose	<input type="checkbox"/> chest		<input type="checkbox"/> shoulder	<input type="checkbox"/> thumb	<input type="checkbox"/> knee	<input type="checkbox"/> great toe
<input type="checkbox"/> mouth	<input type="checkbox"/> stomach		<input type="checkbox"/> upper arm	<input type="checkbox"/> fingers	<input type="checkbox"/> lower leg	<input type="checkbox"/> other toes
<input type="checkbox"/> teeth	<input type="checkbox"/> groin		<input type="checkbox"/> elbow		<input type="checkbox"/> ankle	
<input type="checkbox"/> face			<input type="checkbox"/> forearm			
<input type="checkbox"/> skull			<input type="checkbox"/> wrist			

**Nature of Injury (check appropriate answers)**

<input type="checkbox"/> abrasion	<input type="checkbox"/> puncture	<input type="checkbox"/> heart attack	<input type="checkbox"/> sprain	<input type="checkbox"/> burn	<input type="checkbox"/> traumatic shock
<input type="checkbox"/> bruise	<input type="checkbox"/> laceration	<input type="checkbox"/> hearing loss	<input type="checkbox"/> strain	<input type="checkbox"/> scald	<input type="checkbox"/> electric shock
<input type="checkbox"/> fracture	<input type="checkbox"/> amputation	<input type="checkbox"/> foreign body	<input type="checkbox"/> hernia	<input type="checkbox"/> rash	<input type="checkbox"/> psychosocial
<input type="checkbox"/> concussion	<input type="checkbox"/> bite				
<input type="checkbox"/> other: describe _____					

**Type of Accident that caused Injury (check appropriate answers)**

<input type="checkbox"/> striking against	<input type="checkbox"/> stumbling	<input type="checkbox"/> lifting	<input type="checkbox"/> pushing	<input type="checkbox"/> ingestion
<input type="checkbox"/> struck by	<input type="checkbox"/> slipping	<input type="checkbox"/> bending	<input type="checkbox"/> pulling	<input type="checkbox"/> absorption
<input type="checkbox"/> caught in	<input type="checkbox"/> tripping	<input type="checkbox"/> twisting	<input type="checkbox"/> jumping	<input type="checkbox"/> inhalation
<input type="checkbox"/> stepping on	<input type="checkbox"/> falling	<input type="checkbox"/> stress		<input type="checkbox"/> needlestick
<input type="checkbox"/> other: describe _____				

**Agent of Injury (check)**

<input type="checkbox"/> Vehicle	<input type="checkbox"/> Buildings	<input type="checkbox"/> Mobile Plant	<input type="checkbox"/> Structures
<input type="checkbox"/> Power tools	<input type="checkbox"/> Furniture	<input type="checkbox"/> Other tools	<input type="checkbox"/> Surfaces
<input type="checkbox"/> Animal	<input type="checkbox"/> Heat Stress	<input type="checkbox"/> Materials	<input type="checkbox"/> Sunburn
<input type="checkbox"/> Objects	<input type="checkbox"/> Ionizing radiation	<input type="checkbox"/> Equipment	<input type="checkbox"/> Stress
Vehicle# _____	Type Vehicle _____		

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**SECTION B: TO BE COMPLETED BY THE SUPERVISOR OF THE PERSON INVOLVED WITHIN 48 HRS**

This is an extremely important section as the aim of the accident/incident investigation is to identify preventative action that will avoid recurrence of a similar accident.

Probable cause or causes of accident (check appropriate answers)

- |   |  |   |                                  |
|---|--|---|----------------------------------|
| <input type="checkbox"/> inadequate instruction | <input type="checkbox"/> fault of plant or equipment | <input type="checkbox"/> poor storage     | <input type="checkbox"/> weather |
| <input type="checkbox"/> inadequate workspace   | <input type="checkbox"/> equipment unavailable       | <input type="checkbox"/> poor access      | <input type="checkbox"/> terrain |
| <input type="checkbox"/> assistance unavailable | <input type="checkbox"/> lack of attention           | <input type="checkbox"/> incorrect method |                                  |

Describe the accident \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Attach additional paper or a sketch if applicable)

Witness Names \_\_\_\_\_

How do you rate the potential severity of this incident, i.e. what could have happened?



**PREVENTION OF ACCIDENT/INCIDENT RECURRENCE**

Describe what action is planned or has been taken to prevent a recurrence of the accident, based on the key contributing factors (Please print)

(Immediate) \_\_\_\_\_  
\_\_\_\_\_

(Long Term) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe additional training required and give details on when training when occur:

\_\_\_\_\_  
\_\_\_\_\_

**SECTION C:**

Signed by Supervisor: _____	Date: _____
Signed by Person Involved: _____	Date: _____
Signed by Head of Dept/Area: _____	Date: _____