

Employee Accident Investigation Report with **Slip, Trip and Fall** (STF) Supplement



Name: _____

Program/Job Title: _____

Accident Occur on Agency Premises: Yes No

Accident Location: _____

Date of Injury: _____

Time: _____ a.m. p.m.

Sex: F M

Date Reported: _____

Witnesses: _____

Accident Description: _____



Injured Area	Indicate Area of Injury	Type of Injury
<input type="checkbox"/> Head <input type="checkbox"/> Eye: L / R <input type="checkbox"/> Shoulder: L/R <input type="checkbox"/> Arm: L/R <input type="checkbox"/> Elbow: L / R <input type="checkbox"/> Wrist: L / R <input type="checkbox"/> Hand: L / R <input type="checkbox"/> Finger: Specify _____ <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Hip: L / R <input type="checkbox"/> Leg: L / R <input type="checkbox"/> Knee: L / R <input type="checkbox"/> Ankle: L / R <input type="checkbox"/> Foot: L / R <input type="checkbox"/> Toe: Specify _____ <input type="checkbox"/> Other: _____		<input type="checkbox"/> Abrasion <input type="checkbox"/> Amputation <input type="checkbox"/> Bite: _____ <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Concussion <input type="checkbox"/> Cut / Laceration <input type="checkbox"/> Foreign Body <input type="checkbox"/> Fracture <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Infection <input type="checkbox"/> Pain: _____ <input type="checkbox"/> Puncture <input type="checkbox"/> Rash/Dermatitis <input type="checkbox"/> Respiratory <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Other: _____ _____ _____

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
	<input type="checkbox"/> Bitten by: Human/Animal
	<input type="checkbox"/> Caught Between/In/On
	<input type="checkbox"/> Contact by or with Chemical/Electricity/Other
	<input type="checkbox"/> Equipment Involved: _____
	<input type="checkbox"/> Exposure to: _____
	<input type="checkbox"/> Fall/Slip/Trip : _____
	<input type="checkbox"/> Falling/Flying Object
	<input type="checkbox"/> Handling Materials
	<input type="checkbox"/> Standing on: Ladder/Step Stool/Chair
	<input type="checkbox"/> Struck by: _____
	<input type="checkbox"/> Vehicle Accident: _____
	<input type="checkbox"/> Other: _____

Corrective Action	Action Taken
_____	<input type="checkbox"/> Housekeeping Improved
_____	<input type="checkbox"/> Office Arrangement Changed
_____	<input type="checkbox"/> Safety Equipment Purchased
_____	<input type="checkbox"/> Replace Furniture or Equipment
_____	<input type="checkbox"/> Training for Employee
_____	<input type="checkbox"/> Maintenance & Upkeep Plan
_____	<input type="checkbox"/> Safety Committee Referral
_____	<input type="checkbox"/> Other _____
_____	<input type="checkbox"/> Other _____
_____	<input type="checkbox"/> Other _____
_____	<input type="checkbox"/> 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

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): _____

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: _____

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: _____



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: _____

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

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. _____

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

Prevention: What actions need to be taken to prevent reoccurrence of similar STF incidents? _____

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

Summarize Corrective Actions Taken:	Steps of Investigation Completed
	<input type="checkbox"/> Injured employee interviewed
	<input type="checkbox"/> Coworkers and witnesses interviewed
	<input type="checkbox"/> Site of STF incident toured
	<input type="checkbox"/> Photos taken
	<input type="checkbox"/> Accident investigation report completed
	<input type="checkbox"/> Cause analysis completed
	<input type="checkbox"/> Trend analysis completed
	<input type="checkbox"/> Corrective actions documented and submitted
	<input type="checkbox"/> Responsible parties contacted
	<input type="checkbox"/> Corrective actions implemented
	<input type="checkbox"/> 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

