

Town of Stettler Employee Incident Investigation Report # _____

To be filled out by Supervisor and Worker together.

(office use only)

Date of Incident _____ Time _____

Location _____ Worker(s) _____

Supervisor: _____ Investigator(s): _____

Injuries - Persons Injured

Name _____ Years of Service _____

Address _____ Phone _____

Description of Injury _____

First Aid Given? Yes No By Whom? _____

Transported to Medical Aid? Yes No By Whom? _____

Where to? _____ Name of Doctor _____

WCB Report Filled out? _____ Filed in Personel File? _____

Person(s) Involved / Witnesses

Name	Address	Phone No.

Property Damage:	Unit #:	Cost

Incident Reported By _____ Reported To _____

Date Reported _____ Time Reported _____

Conditions at time of incident (weather, status of job, housekeeping, etc.)

Other Circumstances:

Description of incident (What was the job being done? What equipment, tools, materials, etc. were involved? What happened?) Attach a diagram if necessary.

Immediate? (Unsafe Practices / Conditions)

Underlying? (Personal / Work Environment Factors)

Recommended action(s) to prevent recurrence?

Short Term?

Long Term?

Worker(s) Name: _____ Signature: _____

Supervisor Name: _____ Signature: _____

CAO Signature

Date

Comments:

Safety Coordinator Followup:

Description of Corrective Action(s) Required:	Date to be Completed

Completed: Date: _____ Signature: _____