

Incident, Illness & Injury Investigation Checklist

Information About the Person Involved (Complete separate checklist for each person)			
Person's full name			
Person's full address			
Person's date of birth (dd/mm/yy)			
Person's gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other
Type of person	<input type="checkbox"/> Employee	<input type="checkbox"/> Contractor	<input type="checkbox"/> Other
If employee, date hired (dd/mm/yy)			
If employee, time person began work		<input type="checkbox"/> AM	<input type="checkbox"/> PM
Information About the Event			
Date of event (dd/mm/yy)			
Time of event		<input type="checkbox"/> AM	<input type="checkbox"/> PM
Type of event	<input type="checkbox"/> Incident	<input type="checkbox"/> Illness	<input type="checkbox"/> Injury
File/Case number of event			
If employee, did event result in lost time at work?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, how many days?			
If employee, did event result in transfer/restriction of duties?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How did the event occur?			
Activities that preceded the event?			
Tools and/or equipment involved in the event?			
Result of event – what harm did the person involved suffer?			
What object or substance caused direct harm to the person involved?			
Part of person's body affected?			

Information About First Aid/Medical Aid Provided		
Was first aid/medical aid provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of first aider/medical professional that provided aid		
Location aid was provided		
Was person treated in an emergency room?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was person hospitalized overnight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Investigation completed by		
Signature of investigator		
Date investigation completed (dd/mm/yy)		

Disclaimer

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