ACCIDENT INVESTIGATION REPORT

Chico State Enterprises

Please return to Chico State Enterprises, zip 246
or fax 530-898-6021

Project/Program:	**Location Where Injury Occurred**:
Name of Injured Employee:	**Date of Hire**:
Normal Occupation of Employee:	**Date of Accident**:
Employee Usually Works: ___Hrs. Per Day ___Days Per Week ___ Total Weekly	**Time of Accident**:
Time Employee Began Work: **AM/PM**	**Date Reported to You**:
Did Employee Leave Work Due to Accident? Yes☐ No ☐	**Date**: **Time**: **AM/PM**
Did Employee Return To Work? Yes☐ No☐	**Date**: **Time**: **AM/PM**

Name(s) of Witness(s):

Name, Address and Phone Number of Doctor or Hospital Where Injured Was Treated:

What Was Employee Doing When Injured? (Please be specific, Identify tools, equipment, or materials the employee was using):

How Did The Accident Or Exposure Occur? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary):

Object or Substance That Directly Injured Employee (e.g. the machine employee struck against or which struck him/her/ the vapor or poison inhaled or swallowed; the chemical that irritated the skin; in case of strains, the object being lifted, pulled or pushed):

Describe The Injury or Illness (e.g. cut, strain, fracture, skin rash, etc.):

Part of body Affected (e.g. back, left wrist, right eye, etc.):

What was Done or Failed To Be Done That Contributed To The Accident?

What Actions Have or Will Be Taken To Prevent Recurrence? Indicate date To Be completed. (Use additional sheet if necessary).

1.

2.

3.

Investigation Conducted By: Title: Date:

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