GLENN COUNTY
ACCIDENT INVESTIGATION FORM

INJURED AND/OR REPORTING EMPLOYEE

Name:	Title:
Department:	Phone Number:
Date of Hire:	Time at Present Job:
Supervisor's Name:	Title:

CLIENT/PRIVATE CITIZEN INFORMATION (if applicable)

Name:	Phone Number:	
Home address:	Insurance carrier:	County Premises: Yes ☐ No ☐

EQUIPMENT/BUILDING DAMAGE (if applicable)

Equipment Description:	Building Description:

ACCIDENT INFORMATION

Date of Accident:	Time:
Date Accident Reported:	
Accident Reported To:	Title:
Location of Accident:	
What activity was being performing prior to the accident?	
Describe Accident. Use additional paper if necessary:	
If a person was injured, describe the injury and body part(s) affected: N/A ☐	

MEDICAL CARE		N/A
First Aid Only: Yes ☐ No ☐	Doctor Visit Required: Yes ☐ No ☐	
Medical Provider Utilized:		
For employees only, number of missed workdays, if any:	Dates: to	

SKETCH/DIAGRAM (Use back of paper if more space is needed.)

CAUSAL FACTORS

Describe any Unsafe Acts:

Describe any Unsafe Conditions:

Identify the cause(s) of the Accident:

WITNESS INFORMATION

Name:	Phone #:
Name:	Phone #:
Name:	Phone #:

CORRECTIVE ACTION INFORMATION

What corrective action has been taken or is recommended to prevent a recurrence of a similar accident?	
Has corrective action been completed? Yes ☐ No ☐	If yes, date completed:
If no, please give reason:	
Person responsible for implementing corrective action:	Phone Number:

INVESTIGATION COMPLETED BY

Name:	Date:
Department:	Phone #:
Address:	
Signature:	Title:
Department Safety Representative Signature:	Date:
Department Head Signature:	Date:

FOLLOW UP ACTION TAKEN: