AAG ACCIDENT/INCIDENT INVESTIGATION REPORT FORM

- This form to be completed for **all job-related injuries or illnesses & building/property damage – regardless of extent**.
- People Resource Rep and Supervisor/Manager must be contacted immediately.
- A post-accident drug screen must occur immediately (or immediately following medical treatment) for any AAG employees who are injured or involved in an accident/incident.
- Supervisor/Manager must complete the supervisor section within 24 hours of incident.

Name _____ Job Tile _____
First Middle Last

Date of Incident: Hour: AM PM Time Began Work: AM PM Time Left Work: AM PM

Department Name	Name of Supervisor	Date Reported to Supervisor
Exact Location of Incident:		Name(s) of Witness(es):
If Vehicle Was Involved, List Stock # or Customer Name/VIN/Year/Make/Model/Lic. Plate #		
Were Police Called? YES / NO If Yes, Case # and County		Have Vehicle Inspected for Potential Issues Prior to Putting Back in Service

Describe Accident (If someone was injured, what were they doing? What vehicles, objects, machines, materials or chemicals were involved?):

_____

_____

_____

_____

Regular Days Off	Working Shift AM PM to AM PM

Verify Overtime hrs worked for the previous 4 weeks: _____

Employee Signature: _____ Date: _____

THIS SECTION TO BE FILLED OUT BY PERSON WHO ADMINISTERS FIRST AID OR BY STORE SAFETY CHAIR

ACTION	BODY PART INJURED			NATURE OF INJURY		CAUSE	
FIRST AID ADMINISTERED	HEAD	FACE	EYE	ABRAISION	LACERATION	PUNCTURE	BURN OR SCALD
PEOPLE RESOURCES CONTACTED	NECK	BACK	CHEST	BRUISE	FRACTURE	BURN	CAUGHT IN, UNDER, OR BETWEEN
SENT TO COMPANY DOCTOR	ARM	HAND	FINGER	SPRAIN/STRAIN	FOREIGN BODY	POISON OAK	CUT, PUNCTURE, OR SCAPE
SENT TO EMERGENCY ROOM	LEG	KNEE	ANKLE	COLD INJURY	HEAT INJURY	DERMATITIS	FALL, SLIP, OR TRIP

TIME LOSS	FOOT	TOE		LOSS OF	OCCUPATIONAL		MOTOR VEHICLE
NO INJURY/NEAR MISS	OTHER			CONSCIOUSNESS	ILLNESS		

If first Aid Administered was it by a fellow employee or where they taken to a health care facility, please name who & or where

_____

_____

SUPERVISOR'S INVESTIGATION OF CAUSE (CHECK ONE OR MORE)

Did you personally view the incident site? ☒ Yes ☒ No

Employee Category: ☒ Full Time ☒ Part-time ☒ Intern

UNSAFE BEHAVIORS

- ❑ OPERATING WITHOUT AUTHORITY
- ❑ FAILURE TO WARN OTHERS
- ❑ OPERATING OR WORKING AT UNSAFE SPEED
- ❑ MAKING SAFETY DEVICES INOPERATIVE
- ❑ FAILURE TO SECURE OBJECTS
- ❑ USING UNSAFE EQUIPMENT OR EQUIPMENT UNSAFELY
- ❑ UNSAFE LOADING, MIXING, CARRYING
- ❑ TAKING UNSAFE POSITION OR POSTURE
- ❑ HORSEPLAY
- ❑ FAILURE TO USE PERSONAL PROTECTIVE DEVICES
- ❑ FAILURE OT OBSERVE SAFETY REGULATIONS
- ❑ LACK OF TRAINING OR KNOWLEDGE
- ❑ PREVENTABLE VEHICLE ACCIDENT
- ❑ SLIPS AND FALLS
- ❑ FAILURE TO LOCK OUT/TAG OUT
- ❑ OTHER: _____

UNSAFE CONDITIONS

- ❑ IMPROPERLY GUARDED EQUIPMENT OR MACHINE
- ❑ DEFECTIVE TOOL OR EQUIPMENT
- ❑ POOR HOUSEKEEPING
- ❑ IMPROPER LIGHTING
- ❑ IMPROPER VENTILATION (DUST, FUMES, ETC.)
- ❑ UNSAFE DESIGN OR CONSTRUCTION
- ❑ SLIPPERY OR OTHER UNSAFE SURFACE
- ❑ INADEQUATE WARNING SYSTEM
- ❑ HAZARDOUS STORAGE OR ARRANGEMENT
- ❑ HAZARDOUS APPAREL
- ❑ HAZARDOUS WORK PROCEDURE
- ❑ HAZARDOUS WEATHER OR ENVIRONMENT
- ❑ CONTACT WITH POISONOUS PLANTS, INSECTS, TOXIC CHEMICALS, SKIN IRRITANTS, BITES, ECT.
- ❑ OTHER: _____

TAKE PICTURES OF AREA, VEHICLE & OTHER EQUIPMENT OR OBJECTS INVOLVED & UPLOAD WITH PDF OF THIS COMPLETED FORM TO SAFETY INCIDENT SMARTSHEET.

- REASONS FOR UNSAFE BEHAVIORS (Must be completed by Supervisor)

_____

_____

_____

_____

- REASONS FOR UNSAFE CONDITION (Must be completed by Supervisor)

_____

_____

_____

_____

- WHAT PRACTICAL CORRECTIVE ACTION WILL BE TAKEN BY SUPERVISIOR OR BY EMPLOYEES TO PREVENT RECURRENCE? (Must be completed by Supervisor.) Note: The wording "be more careful" is unacceptable, as it does not present a viable solution. If the cause is properly identified, there should be several solutions.

_____

_____

_____

_____

_____

_____

DEPT MANAGERS SIGNATURE _____ DATE _____

IF THIS WAS A MOTOR VEHICLE ACCIDENT WHICH OCURRED OFF-SITE CONTINUE TO THE NEXT PAGE

- **Get copies of all party's insurance information, and attach**
- **Get statements from all parties and witnesses involved, and attach**

Additional Accident Information

Name _____ Employee ___ Customer ___ Other ____

Address _____City _____ State _____

Phone _____

Injuries YES / NO

If YES, describe medical attention given (including name of Medical Center sent to)

_____

_____

Vehicle Involved: Year _____ Make _____ Model _____VIN_____

Vehicle owned by _____ License Plate # _____

Name _____ Employee ___ Customer ___ Other ____

Address _____ City _____ State _____

Phone _____

Injuries YES / NO

If YES, describe medical attention given (including name of Medical Center sent to)

_____

_____

Vehicle Involved: Year _____ Make _____ Model _____ VIN_____

Vehicle owned by _____ License Plate # _____

Name _____ Employee ___ Customer ___ Other ____

Address _____ City _____ State _____

Phone _____

Injuries YES / NO

If YES, describe medical attention given (including name of Medical Center sent to)

_____

_____

Vehicle Involved: Year _____ Make _____ Model _____ VIN_____

Vehicle owned by _____ License Plate # _____

Were Police called? YES / NO If YES, Case # _____ County _____