Catholic Mutual CARES

ACCIDENT INVESTIGATION/CORRECTIVE ACTION REPORT

I. Identification of the Accident:

Name of Injured Party: _____ Location of Accident: _____
Date of Accident: _____ Time of Accident: _____

II. Nature of Injury:

Body Part(s) Injured: _____
Full accident/incident details – what happened and why: _____

_____

_____

Witness(es) – Name/Address/Contact: _____

III. Accident Prevention Information:

Equipment, tool, or item causing injury: _____
Was the accident caused by failure to use or observe safety practices, policies, or regulations? **YES/NO** _____

IV. Corrective Action:

What corrective action can be taken to prevent a recurrence of this accident/injury?

_____

_____

Comments/Recommendations (by Safety Committee, Safety Director, or Supervisor):

_____

_____

Person(s) responsible for corrective action: _____
Date by which action is to be taken: _____
Safety Director/Manager Review: _____

Signatures:

Name: _____ Job Title: _____

_____ _____

Actions Completed: _____ Date: _____ By: _____

CATHOLIC MUTUAL GROUP
COMMITMENT + EXPERTISE + STABILITY