

# Employee Accident Investigation Report with Slip, Trip and Fall Supplement



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| Injured Area   | Indicate Area of Injury | Type of Injury  |
|--|-------------------------|---|
| <p>1 <input type="checkbox"/> Head</p> <p>2 <input type="checkbox"/> Eye: L / R</p> <p>3 <input type="checkbox"/> Shoulder: L/R</p> <p>4 <input type="checkbox"/> Arm: L/R</p> <p>5 <input type="checkbox"/> Elbow: L / R</p> <p>6 <input type="checkbox"/> Wrist: L / R</p> <p>7 <input type="checkbox"/> Hand: L / R</p> <p>8 <input type="checkbox"/> Finger:</p> <p>Specify _____</p> <p>9 <input type="checkbox"/> Back</p> <p>10 <input type="checkbox"/> Chest</p> <p>11 <input type="checkbox"/> Abdomen</p> <p>12 <input type="checkbox"/> Pelvis</p> <p>13 <input type="checkbox"/> Hip L / R</p> <p>14 <input type="checkbox"/> Leg: L / R</p> <p>15 <input type="checkbox"/> Knee: L / R</p> <p>16 <input type="checkbox"/> Ankle: L / R</p> <p>17 <input type="checkbox"/> Foot: L / R</p> <p>18 <input type="checkbox"/> Toe:</p> <p>Specify _____</p> <p>19 <input type="checkbox"/> Other: _____</p> |                         | <p>1 <input type="checkbox"/> Abrasion</p> <p>2 <input type="checkbox"/> Amputation</p> <p>3 <input type="checkbox"/> Bite: _____</p> <p>4 <input type="checkbox"/> Bruise</p> <p>5 <input type="checkbox"/> Burn</p> <p>6 <input type="checkbox"/> Concussion</p> <p>7 <input type="checkbox"/> Cut / Laceration</p> <p>8 <input type="checkbox"/> Foreign Body</p> <p>9 <input type="checkbox"/> Fracture</p> <p>10 <input type="checkbox"/> Hearing Impaired</p> <p>11 <input type="checkbox"/> Infection</p> <p>12 <input type="checkbox"/> Pain: _____</p> <p>13 <input type="checkbox"/> Puncture</p> <p>14 <input type="checkbox"/> Rash/Dermatitis</p> <p>15 <input type="checkbox"/> Respiratory</p> <p>16 <input type="checkbox"/> Strain/Sprain</p> <p>17 <input type="checkbox"/> Other: _____</p> <p>_____</p> |

Did injured employee miss work?  Yes  No

Dates: \_\_\_\_\_

Form Completed by: \_\_\_\_\_

Date: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Program Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Investigation Report

| Cause of Accident | Source   |
|-------------------|--|
|                   | 1 <input type="checkbox"/> Bitten by: Human/Animal                       |
|                   | 2 <input type="checkbox"/> Caught Between/In/On                          |
|                   | 3 <input type="checkbox"/> Contact by or with Chemical/Electricity/Other |
|                   | 4 <input type="checkbox"/> Equipment Involved: _____                     |
|                   | 5 <input type="checkbox"/> Exposure to _____                             |
|                   | 6 <input type="checkbox"/> Fall/Slip/Trip : _____                        |
|                   | 7 <input type="checkbox"/> Falling/Flying Object                         |
|                   | 8 <input type="checkbox"/> Handling Materials                            |
|                   | 9 <input type="checkbox"/> Standing on: Ladder/Step Stool/Chair          |
|                   | 10 <input type="checkbox"/> Struck by: _____                             |
|                   | 11 <input type="checkbox"/> Vehicle Accident: _____                      |
|                   | 12 <input type="checkbox"/> Other: _____                                 |

| Corrective Action | Action Taken  |
|-------------------|---|
| _____             | 1 <input type="checkbox"/> House Keeping Improved         |
| _____             | 2 <input type="checkbox"/> Office Arrangement Changed     |
| _____             | 3 <input type="checkbox"/> Safety Equipment Purchased     |
| _____             | 4 <input type="checkbox"/> Replace Furniture or Equipment |
| _____             | 5 <input type="checkbox"/> Training for Employee          |
| _____             | 6 <input type="checkbox"/> Maintenance & Upkeep Plan      |
| _____             | 7 <input type="checkbox"/> Safety Committee Referral      |
| _____             | 8 <input type="checkbox"/> Other _____                    |
| _____             | 9 <input type="checkbox"/> Other _____                    |
| _____             | 10 <input type="checkbox"/> Other _____                   |
| _____             | 11 <input type="checkbox"/> Other _____                   |
| _____             |   |
| _____             |   |

Person responsible for corrective actions: \_\_\_\_\_ Target completion date: \_\_\_\_\_

Signature of person responsible for corrective actions: \_\_\_\_\_

Date corrective actions completed: \_\_\_\_\_ Additional follow up needed?  Yes  No

**Slip, Trip, Fall Supplement: ADDITIONAL INFORMATION TO BE COMPLETED FOR ALL STF INJURIES**

Provide a description of what happened (outline key facts of the STF event): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Consider the following items and document any that may have been contributing factors to the event:

What job task or activity was the employee performing at the time of the incident: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Location of the STF Incident: \_\_\_\_\_

Snow/Ice Accumulation: \_\_\_\_\_

Other Contaminants/Items on Walking Surface: \_\_\_\_\_

Type or Condition of Footwear: \_\_\_\_\_

Type or Condition of Walking Surface/Flooring Material: \_\_\_\_\_

Housekeeping Issues: (Spill Cleanup Procedures, Wet Floor Signs Available, etc) \_\_\_\_\_

\_\_\_\_\_

Entry Mats/Rugs: \_\_\_\_\_

Adequacy of Lighting in Area: \_\_\_\_\_

Equipment/Tools being used: \_\_\_\_\_

Other Contributing Factors: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## STF Analysis and Follow Up:

Location of the STF Incident: \_\_\_\_\_

Snow/Ice Accumulation: \_\_\_\_\_

Other Contaminants/Items on Walking Surface: \_\_\_\_\_

Type or Condition of Footwear: \_\_\_\_\_

Type or Condition of Walking Surface/Flooring Material: \_\_\_\_\_

Housekeeping Issues: (Spill Cleanup Procedures, Wet Floor Signs Available, etc) \_\_\_\_\_

Entry Mats/Rugs: \_\_\_\_\_

Adequacy of Lighting in Area: \_\_\_\_\_

Equipment/Tools being used: \_\_\_\_\_

Other Contributing Factors: \_\_\_\_\_

Cause Analysis: Based on the review of facts and gathering of information, what are the underlying causes(s) that largely contributed to the incident? \_\_\_\_\_

Trend Data Analysis: In review of other sources of data such as work comp loss runs, OSHA logs and injury reports, describe any trends that may exist between other similar STF injuries. \_\_\_\_\_

Injured Employee: Has the injured worker had a previous fall? \_\_\_\_\_

Prevention: What actions need to be taken to prevent reoccurrence of similar STF incidents? \_\_\_\_\_

Safety Team: Has the incident report been submitted to a Safety Team or Committee for review? \_\_\_\_\_

| Summarize Corrective Actions Taken: | Steps of Investigation Completed                                       |
|-------------------------------------|--|
| _____                               | 1 <input type="checkbox"/> Injured employee interviewed                |
| _____                               | 2 <input type="checkbox"/> Coworkers and witnesses interviewed         |
| _____                               | 3 <input type="checkbox"/> Site of STF incident toured                 |
| _____                               | 4 <input type="checkbox"/> Photos taken                                |
| _____                               | 5 <input type="checkbox"/> Accident investigation report completed     |
| _____                               | 6 <input type="checkbox"/> Cause analysis completed                    |
| _____                               | 7 <input type="checkbox"/> Trend analysis completed                    |
| _____                               | 8 <input type="checkbox"/> Corrective actions documented and submitted |
| _____                               | 9 <input type="checkbox"/> Responsible parties contacted               |
| _____                               | 10 <input type="checkbox"/> Corrective actions implemented             |
| _____                               | 11 <input type="checkbox"/> Other : _____                              |
| _____                               | _____  |

Person responsible for corrective actions: \_\_\_\_\_ Target completion date: \_\_\_\_\_

Signature of person responsible for corrective actions: \_\_\_\_\_

Date corrective actions completed: \_\_\_\_\_

Additional follow up needed?  Yes  No

