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$&&,'(17 ,19(67,*$7,21 5(3257
Information contained on this form is for official use only, for the exclusive benefit of the C 6 8 / %

[redacted]ESTIGATION: TO BE COMPLETED BY SUPERVISOR

[redacted]	PHONE/EXT	DATE REPORTED	TIME REPORTED

[redacted]ion: [ ] On-Site [ ] Off-Site Overtime Involved? [ ] Yes [ ] No
[redacted]ess and/or worksite description:

Injury / Illness / ,QFLGHQW Body Part(s) Affected:

[redacted] 3OHDVH FKHFN ER[LI DUH SRVVLEOH LQMXU\ QR SURSHUW\ GDPDJH RU ERGLO\ LQMXU\ LQ

[redacted]CRIBE SEQUENCE OF EVENTS (Specify activity, policy or procedure performed prior to incident. *Use additional sheets as* [redacted]*ed)*

[redacted] DID THE INJURY / ILLNESS ,1&,'(17 OCCUR? (Please include any Safety Policy and Procedures that were not followed.
[redacted]H *additional sheets as needed*):

[redacted]NESSES: [ ] Yes [ ] 1RDWWDFKGDWHGDQGVLJQHG:LWQHVV6WDWHPHQWIRUPDJHWRWKLVGRFXPHQW

[redacted]TOS > @<HV > @1R DWWDFKGDWHGDQGVLJQHG:LWQHVV6WDWHPHQWIRUPDJHWRWKLVGRFXPHQW

[redacted]LG WKH DFFLGHQW RFFXU GXULQJ WKH KRXUV RI QRUPDO DVVLJQHG GXWLHV"
[ ] Yes [ ] No

Was this injury/illness/ incident caused by unsafe wor N HQYLURQPHQW RU HTXLSPHQW PDOI
[ ] Yes [ ] No (If yes, explain and attach photos)

[redacted]R QRW ZLVK WR ILOH D :RUNHUV &RPSHQVDWLRQ &ODLP IRUP RU VHHN PHGLFDO
[redacted]ULJKW WR ILOH D FODLP 3HU /& DQ HPSOR\HH KDV \HDU IURP WKH GDWH R
[redacted]UP

[redacted] (PSOR\HH 6LJQDWXUH BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB
'DWH

[redacted] Date/Time:

Department Manager Name Review and Approval: (print)	Signature:	Date/Time:

7KLVIRUPVKDOOEHFRPSOHWHGDQGVHQWRWKH:RUNHUV&RPSHQVDWLRQ&RRUGLQDWRU
ZLWKLQKRXUVRIWKHLQFLGHQW)RUTXHVWLRQVSOHDVHFDOO

™" H ó0H ø #'*z H ôg$Hï3>ãDŒ —.fOO.48 0 Y 8 7440.42 O 749-6.9980.16 21.024 Td (2)258.89EE0.429724 06.9980.16 [(J.48

WITNESS STATEMENT FORM

To be completed by incident witness:

Information about the person making this statement: (Please print or write clearly.)

First name _____ Last name _____

Job title _____ Department_____ Division _____

Department Manager _____ Department Supervisor _____

Describe exactly what you observed, regarding this incident. (Use additional sheets if needed)

Date of Injury / Illness _____Time of incident _____AM / PM

Location of incident _____

Other witnesses _____

Statement _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Witness signature **Date/Time**

Box below to be completed by Dept./Div. representative:

Statement received by (print name and signature) _____

Date/time statement received _____