FARRIOR & SONS, INC. CONSTRUCTION
COMMERCIAL • INDUSTRIAL • METAL BUILDINGS

SUBCONTRACTOR ACCIDENT INVESTIGATION REPORT

DATE: _____

COMPLETED BY: _____

I. General Information

Company Name: _____ Safety Director's Name: _____ Telephone #: _____

Employee Name: _____ Job Title: _____

Date of Occurrence: _____ Time: _____ AM or PM

Date of First Treatment: _____ Supervisor: _____

Location of Accident *(Be Specific)* _____

_____

II. Medical Treatment Provided? Yes No

Physician/Hospital authorized by employer? Yes No

Name of hospital or physician: _____

Description of Injuries: _____

_____

_____

III. Description of Incident *(How did it occur? Why? List objects, tools, equipment used. Circumstances? List assigned duties.)*

_____

_____

_____

What was employee doing when accident occurred? Employee states: _____

_____

Injured employee's description of occurrence: _____

_____

Witnesses' Names *(Use a separate sheet for statements):* _____

IV. Analysis

Accident caused by: Unsafe Act _____ Unsafe Condition _____

Describe: _____

_____

V. Preventive and/or Corrective Action

Steps needed to prevent re-occurrence: _____

Persons responsible for implementation of these preventions: _____

_____