RUTGERS UNIVERSITY
ACCIDENT INVESTIGATION FORM

Name of Injured Employee: ____________________________________
Date of Accident: ____________________________________
Job Title: ____________________________________
Time of Accident: ____________________________________
Department: ____________________________________
Location of Accident: ____________________________________
Name of Witness(s): ____________________________________

Description of ACCIDENT

Task Being Performed:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Equipment, Tools, Personal Protective Equipment, Procedures Being Used:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Description on Injury/Illness (include accident type, injury type and body part injured):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Describe All Contributing Factors:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Description of Work Area:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Injured Employee’s Account of Accident:
______________________________________________________________
______________________________________________________________
______________________________________________________________

Witness's Account of Accident:
______________________________________________________________
______________________________________________________________
______________________________________________________________

What Were the Basic Causes of the Accident (usually multiple causes)?:
______________________________________________________________
______________________________________________________________
______________________________________________________________

Corrective Measures to be Implemented to Prevent Similar Reoccurrence:
______________________________________________________________
______________________________________________________________
______________________________________________________________

Investigator's Name:  ____________________________________
Date of Investigation: ____________________________________

If you are printing and filling out this form for an Accident that has occurred on the Busch Livingston Campus, mail this form to:

BL FMS
Work Control Center
77 Street 1603
Livingston Campus