

ACCIDENT INVESTIGATION REPORT

(Send to Production Office Coordinator when completed.)

*To be completed for EVERY injury or illness, regardless of severity.
For serious injuries or illnesses, see Form 4: Serious Incident Reporting Procedures.*

EMAIL OR FAX (818) 954-2805. YOU MAY ALSO SEND A COPY TO YOUR PRODUCTION SAFETY REPRESENTATIVE. ____

PRODUCTION NAME: _____

• DATE: _____

INJURED'S NAME: _____

• TITLE: _____

DATE OF ACCIDENT: _____

• TIME OF ACCIDENT: _____ AM ____ PM ____

LOCATION OF ACCIDENT: _____

Type of Injury/Illness

(Check all that apply)

Fracture	Amputation	Head Injury	1 st Degree Burn	Foreign Body in Eye	Bite/Sting
Strain	Laceration	Neck Injury	2 nd Degree Burn	Contact Dermatitis	Splinter
Sprain	Avulsion	Back Injury	3 rd Degree Burn	Allergic Reaction	Nausea
Dislocation	Abrasion	Abdomen Injury	Tooth Injury	Rash	Illness*
Contusion	Puncture	Crushing Injury	Hearing Loss	Infection	Other*

• Describe Illness or Other:

Injured Part of Body

(Check all that apply)

	Head	Chest	Shoulder	Wrist	Upper Leg	Foot	Eye	Mouth
Right	Neck	Ribs	Upper Arm	Back of Hand	Knee	Toe	Nose	Tooth
Left	Back	Abdomen	Elbow	Palm of Hand	Lower Leg	Forehead	Cheek	Throat
	Buttocks	Pelvis Area	Lower Arm	Finger (Digit_____)	Ankle	Ear	Chin	Other*

• Describe Other:

Explain Cause of Accident and Nature of Injury: (DO NOT SPECULATE)

Corrective Action Taken to Prevent Recurrence:

Witnesses (if any):

Form Completed By (Print):

Title:

Signature: _____ Date: _____