Safety Review Guide

Employee's Name		Today's Date	
Job Title		Regular Dept.	
Date of Incident		Time of Incident	
Location of Incident (Specific address or plant or department)			
Description of Incident			
Did employee seek outside medical treatment?	[ ] Yes [ ] No		
Did employee return to work?	[ ] Yes [ ] No		
Did employee return to regular duties	[ ] Yes [ ] No		
Were there any witnesses	[ ] Yes [ ] No		
If yes, who?			

Part of body injured:			
Type of Incident			
[ ] Struck by	[ ] Slip/Fall	[ ] Burn/Cold	
[ ] Struck against	[ ] Caught in	[ ] Cumulative Trauma	
[ ] Lifting/Overexertion	[ ] Inhalation	[ ] Other:	
In your opinion, what was the root cause of the incident?			
In your opinion, what could be done to prevent the incident from reoccurring?			
Signed		Date	

Management/Safety Committee Review

Has this type of incident happened before?	[ ] Yes [ ] No		
Is employee consultation needed?	[ ] Yes [ ] No		
What can be done to prevent reoccurrence			
Project Leader		Completion Target	
Signed		Date	

This is not the Notice of Injury Form.
This form is to be used for your safety committee review.