

## 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did employee return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did employee return to regular duties <input type="checkbox"/> Yes <input type="checkbox"/> No			
Were there any witnesses <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, who?			

Part of body injured:			
Type of Incident			
<input type="checkbox"/> Struck by	<input type="checkbox"/> Slip/Fall	<input type="checkbox"/> Burn/Cold	
<input type="checkbox"/> Struck against	<input type="checkbox"/> Caught in	<input type="checkbox"/> Cumulative Trauma	
<input type="checkbox"/> Lifting/Overexertion	<input type="checkbox"/> Inhalation	<input type="checkbox"/> 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	

<b>Management/Safety Committee Review</b>			
Has this type of incident happened before?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is employee consultation needed?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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.**