

Safety Committee - Employee Accident Review Form

Employee: _____ Dept: _____
Date of Incident: _____ Date County Notified: _____

Accident Report Completed: Yes / No First Report of Injury Completed: Yes / No

Date submitted to HR: _____ Work Missed: Y/N How many days: _____

Location of Accident: _____ County Property _____ Public or Private Property: _____
Other: _____

Witness 1: _____ Dept/Phone: _____

Witness 2: _____ Dept/Phone: _____

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Date reviewed by Safety Committee: _____

Date of last incident reviewed by Safety Committee: _____

Line of Duty: _____ Yes _____ No Time of Accident: _____ AM / PM

Injury/Loss: _____

Findings of Committee upon review: (list unsafe conditions present and/or actions planned or taken to prevent further incidents)

Further Action Necessary: _____

Corrective Action recommended to Dept Head:

Corrective Action Taken: *Return Copy to HR or Safety Director within Ten Days of recommendation*

Corrective Action Recommendation rejected for following reason/s:

Signature : _____ **Title:** _____ **Date:** _____