

SLIP/TRIP/FALL ACCIDENT INVESTIGATION REPORT



Department/Division		Location		
Exact location (Inside, outside, etc.)	On premises?	Date of incident	Time AM PM	Date reported
Name of slip/trip/fall victim:		Names of witnesses:		
Occupation of victim/Department Code:		Type of Shoes/Soles condition:		
Part of body injured by fall:				
Floor/Ground Condition:				
Event, object, or condition contributing to fall:				
Slip/Trip/Fall caused by: <input type="checkbox"/> Wet/slippery conditions <input type="checkbox"/> Winter Weather <input type="checkbox"/> Object on Floor <input type="checkbox"/> Cords/Hoses				

DESCRIPTION

Describe clearly how the fall occurred, including distance of fall		
Did injured employee leave work	Date	Time AM PM
Doctor		
Hospital		Expected date of return

ANALYSIS

What acts, failures to act and or conditions contributed most directly to this fall?	
Photos taken of fall area? Yes (include with report) No	
Loss Severity Potential High(Major) Medium (Serious) Low (Minor)	Probable Recurrence Rate High(Frequent) Medium (Occasional) Low (Rare)

PREVENTION

What action has or will be taken to prevent recurrence?
Who's responsible for follow up actions?
Date Completed:

Investigated by	Date	Manager	Date
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