

Flagler County
SUPERVISOR'S INCIDENT INVESTIGATION FORM

Name of involved employee: _____

Social Security Number: _____ Age: _____

Department: _____ Job Title: _____

Date of Incident: _____ Time of Incident: _____ am / pm

Accident Description (What happened?): _____

Nature of injury: _____

Body part injured: _____

Cause of accident: _____

Was vehicle or equipment involved? _____ Yes _____ No

If so, explain: _____

Unsafe acts or conditions: _____

Safety training provided due to accident (action taken or recommended): _____

Are long term corrective actions needed? _____ Yes _____ No

If so, what is recommended? _____

Investigated by: _____ Date: _____

Follow up action by safety coordinator: _____

_____ Date: _____

Please complete this form and return to Human Resources with other necessary documentation within 24 hours after the incident.