



Galveston County Safety Manual

ATTACHMENT 2

ACCIDENT REPORT AND INVESTIGATION FOR EMPLOYEE INJURIES ONLY

(Part 1 Must Be Completed Immediately And Sent To Appropriate Personnel)

Part 1

Name of Employee Injured: _____ Sex: ___ SS#: _____

Date of Birth: _____ Mailing Address: _____

Home Phone: _____ Date lost time began: _____

Marital Status: _____ No. of Dependent Children: _____

Spouse's Name: _____

Date of Injury: _____ Time of Injury: _____ a.m. p.m.

Date Employee Reported Injury: _____

Treating Doctor's Name: _____

Address: _____

Ph # _____

Was employee doing his/her regular job? ___Yes ___No If no, why was job being performed:

Address or Location Where Injury Occurred:

Name(s) of Witness to Injury (name, address, ph.#) (Attach additional sheet if necessary)



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Date of Investigation: _____

Supervisor's Signature

Date

Corrective Action/Preventive Measures Taken or Recommended (Attach additional sheet if necessary)

The preventive measure(s)/corrective action(s) is ___ temporary. ___ permanent.

Employee responsible for ensuring corrective measures/actions are taken:

Date Corrective/Preventive Measures Completed: _____

Department Head's Signature _____

Date _____

Associate Facilities Manager Signature _____

Date _____