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**LUZERNE COUNTY ACCIDENT INVESTIGATION
AND
CORRECTIVE ACTION REPORT**

Department / Facility: _____

Date of Report: _____ **Date of Injury:** _____

Last Day Worked: _____ **Date Returned to Work:** _____

Injured Employee's Name: _____

Date of Birth: _____ **Job Title:** _____

Location of Accident: _____
(Be Specific)

Time of Accident: _____ **Bodypart(s) Injured:** _____
(Be specific as to left / right and location)

Nature of the Injury: _____

Description of What Occurred:
(Attach photographs, diagrams or other supporting documentation)

Causes of the Accident:

Indicate most significant cause by underlining.
(carelessness is a general term and should be avoided)

Names and Contact Information of Witnesses:

Name	Address	Phone Number
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Corrective Action to be taken to Prevent Re-Occurrences:

(Required to be completed by Supervisor / Manager)

- Guard Condition
- Obtain Personal Protective Equipment
- Eliminate Condition
- Train/Re-Train Employee and/or Others
- Change Procedure / Policy
- Other _____
- Provide Warning of Condition

Explain the Corrective Action to be taken: _____

Date Corrective Action will be Completed: _____

Person Responsible for Corrective Action:

Person Completing Form: _____ **Phone:** _____