



## Slip/Trip and Fall Accident Investigation Report

Description		
Owner/Operator:		
Location Address:	Did accident occur on premise?	
Date of occurrence:	Time:	Date Reported:
Name of victim:	Name of witness:	
Occupation of victim:	Shoe/soles condition:	
Part of body injured:		
Floor condition:		
Object, equipment, substance or task contributing to fall:		
Clearly describe how the fall occurred:		
Did injured party miss work?	Date:	Time:
Doctor:		
Hospital:	Expected date of return:	

Analysis
What acts, failures to act and/or conditions contributed most directly to this fall?
Loss severity potential: <input type="checkbox"/> High (Major) <input type="checkbox"/> Medium (Serious) <input type="checkbox"/> Low (Minor)
Probably recurrence rate: <input type="checkbox"/> High (Frequent) <input type="checkbox"/> Medium (Occasional) <input type="checkbox"/> Low (Rare)
What action has or will be taken to prevent recurrence?

Reported by:	Email:	Phone:
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