



County of Marin
**Employee Accident/Injury/Illness
Investigation Report Form**
Risk Management Division, County Administrator's Office
PMR 42 – Benefits

EMPLOYEE ACCIDENT/INJURY/ILLNESS INVESTIGATION REPORT

Employee name: _____ Department: _____

Date of accident/injury/illness: _____

Person(s) conducting investigation (include title): _____

Witnesses (If none, so state): _____
_____ (Attach witnesses' statements).

Describe workplace condition, employee work practice or equipment which caused the accident/injury/illness [NOTE: Preserve faulty equipment as evidence so that the County may seek reimbursement from a responsible third party]: _____

Describe recommended actions to prevent reoccurrence: _____

Is action plan required to correct hazard: ____ Yes ____ No

If Yes, date plan submitted to Program Administrator(s): _____

Until corrected, describe actions taken to protect employees in the interim: _____

Person responsible for corrective action: _____

Title: _____ Date correction completed: _____

Signature of person responsible for corrective action: _____

Signature of Supervisor: _____