



SUPERVISOR'S INCIDENT INVESTIGATION

EMPLOYEE INFORMATION

Employee Name: _____ Job Title: _____

Regular Employee? Yes No If No, Explain: _____

Was any informal or formal personnel action considered or taken against the employee within the previous twelve months? Yes No Explain: _____

Has the employee ever reported any previous physical condition/s associated with work or non-work activities (second job, sports, etc. that could be related to or aggravated by this injury)? Yes No
If Yes, explain: _____

INJURY/ILLNESS INFORMATION

Type of Incident: Injury First Aid Near Miss

Date of Injury/Incident: _____ Time: _____ Date Reported: _____

How was injury/incident reported? In person Phone Other: _____

Did anyone witness the injury? Yes No If so, Who: _____

- Please Attach Witness Statement to Investigation Report

Employee: Stayed on Job Went Home Went to Physician/Clinic Other

Where did injury/incident occur? (Be specific, including building & room number, if applicable)

Where pictures taken? Yes No

Describe how the injury occurred: (Example: employee was walking down the stairs, tripped & fell injuring right knee on the cement; employee was lifting a box, felt sharp pain in lower back.)

Body Part: (Check appropriate box(s) and on the line provided specify the location by indicating LE for Left, RT for Right, BO for Both, FR for Front and BA for Back.)

<input type="checkbox"/> Head/Skull _____	<input type="checkbox"/> Arm _____	<input type="checkbox"/> Leg _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Back, Upper _____
<input type="checkbox"/> Nose _____	<input type="checkbox"/> Elbow _____	<input type="checkbox"/> Hip _____	<input type="checkbox"/> Chest _____	<input type="checkbox"/> Back, Mid _____
<input type="checkbox"/> Ear _____	<input type="checkbox"/> Shoulder _____	<input type="checkbox"/> Foot _____	<input type="checkbox"/> Lung _____	<input type="checkbox"/> Back, Lower _____
<input type="checkbox"/> Tooth _____	<input type="checkbox"/> Finger _____	<input type="checkbox"/> Knee _____	<input type="checkbox"/> Abdomen _____ <input type="checkbox"/>	<input type="checkbox"/> Neck _____
<input type="checkbox"/> Mouth _____	<input type="checkbox"/> Wrist _____	<input type="checkbox"/> Toe _____	Mental Trauma _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Eye _____	<input type="checkbox"/> Hand _____			

Nature of Injury: (Check appropriate box)

<input type="checkbox"/> Irritation/inflammation	<input type="checkbox"/> Strain/Sprain	<input type="checkbox"/> Emotional Stress
<input type="checkbox"/> Trauma/Contusion (Bruise)	<input type="checkbox"/> Fracture	<input type="checkbox"/> Exposure (to what): _____
<input type="checkbox"/> Puncture/Laceration	<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Bite	

Cause of Incident/Injury: (Check appropriate box/es.)

- | | |
|---|--|
| <input type="checkbox"/> Rules/procedures known, but not followed | <input type="checkbox"/> Uneven or slippery surface |
| <input type="checkbox"/> Incorrect body position in relation to work | <input type="checkbox"/> Lack of training or skill |
| <input type="checkbox"/> Incorrect tools or mechanical aids used | <input type="checkbox"/> Exposure (chemical, noise, etc.) |
| <input type="checkbox"/> Equipment operated incorrectly | <input type="checkbox"/> Faulty/broken equipment |
| <input type="checkbox"/> Protective equipment not used | <input type="checkbox"/> Congested area/poor housekeeping |
| <input type="checkbox"/> Protective equipment used improperly | <input type="checkbox"/> Animal or insect |
| <input type="checkbox"/> Distraction/lack of required attention to task | <input type="checkbox"/> Action of another person |
| <input type="checkbox"/> Horseplay/Teasing | <input type="checkbox"/> Conflict with supervisor |
| <input type="checkbox"/> Physical or mental impairment | <input type="checkbox"/> Environmental factors (weather, lighting, etc.) |
| | <input type="checkbox"/> Other: _____ |

Source of Incident/Injury: (Check appropriate box.)

- | | | | |
|-----------------------------------|--|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Equipment/Tools | <input type="checkbox"/> Material | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Objects | <input type="checkbox"/> Environment | <input type="checkbox"/> Person | |

Was this accident preventable? Yes No

What did the injured worker do or failed to do that contributed to the accident: _____

Was the injured employee properly trained for what was being done? Yes No

Was another co-worker involved in the accident? Yes No

If yes list the names: _____

Was another company/individual involved in the accident? Yes No

If yes list the name and contact information: _____

What did the other person do or fail to do that contributed to the accident? _____

Preventative Action Required:

- | | |
|--|--|
| <input type="checkbox"/> Enforce safety procedures | <input type="checkbox"/> Update or revise procedures |
| <input type="checkbox"/> Provide more complete job instruction | <input type="checkbox"/> Submit work order to correct unsafe condition |
| <input type="checkbox"/> Provide personal protective equipment | <input type="checkbox"/> Date work order submitted: _____ |
| | <input type="checkbox"/> Other: _____ |

Is there any reason to believe this may NOT be a valid claim? No Yes

Prepared by _____
(Signature) (Please Print Name)

Site _____ Date _____