SUPERVISOR'S INCIDENT INVESTIGATION REPORT

Employee Name:		Date of Birth:	
Employee Occupation:		Department/Site:	
Employee Phone:		Employee Email:	

Date of Incident:		Time of Incident:	_____ AM _____ PM

On Employer's Property? ☐ Yes ☐ No

Location of Incident:

Date Incident Reported:		Reported Within 24 hours: ☐ Yes ☐ No	

If not reported within 24 hours explain why:

Was employee provided a claim form (DWC-1)? ☐ No ☐ Yes Date: _____

Did employee sign and return the claim form? ☐ No ☐ Yes Date: _____

Type of medical treatment required:

- ☐ Clinic
- ☐ Emergency room
- ☐ Paramedics or EMT
- ☐ Hospitalized overnight
- ☐ First Aid
- ☐ Medical treatment refused
- ☐ No treatment needed

Was OSHA Notified ☐ YES ☐ NO
If Yes, complete
By whom: _____
Date: _____ Time: _____
OSHA Confirmation #:

Medical treatment provider (name and address of facility):

Name and title of person to whom the incident was reported:	

Describe what was the employee doing at the time of the incident? (attach separate sheet, if necessary)

Describe how the incident occurred: (attach separate sheet, if necessary)

Type of Injury:

- ☐ Amputation/severance
- ☐ Bite/sting
- ☐ Burn
- ☐ Cancer
- ☐ Contusion, blunt trauma
- ☐ Crush
- ☐ Dermatitis
- ☐ Dislocation
- ☐ Fracture
- ☐ Inflammation
- ☐ Internal
- ☐ Puncture, penetrating trauma
- ☐ Repetitive motion injury
- ☐ Sprain/strain
- ☐ Tendonitis/synovitis
- ☐ Other: _____

Cause of Injury:

- ☐ Absorption, ingestion, inhalation
- ☐ Animal or insect
- ☐ Burn, scald, temperature extreme
- ☐ Caught in or between
- ☐ Cumulative Trauma
- ☐ Cut, puncture or scrape
- ☐ Electrical current
- ☐ Equipment, tools, machinery
- ☐ Explosion
- ☐ Foreign body
- ☐ Lifting
- ☐ Motor vehicle
- ☐ Pushing, pulling
- ☐ Repetitive motion
- ☐ Rubbed or abraded
- ☐ Slip, trip or fall
- ☐ Struck against, by
- ☐ Miscellaneous causes
- ☐ Other: _____

Employee Name:		Date of Incident:	

Did employee lose time from work? ☐ No ☐ Yes **First day of lost time:**

Has employee returned to work? ☐ No ☐ Yes **Date returned:** _____
☐ Full Duty
☐ Modified Duty – Describe:

Was the incident witnessed? ☐ Yes ☐ No (list witnesses below. Attach separate sheet, if necessary)

Name:	Name:
Address:	Address:
City, State Zip:	City, State Zip:
Phone:	Phone:

Was any other employee injured? ☐ Yes ☐ No If "Yes," please list:

Check all conditions that apply:

Equipment
- ☐ Defective machine
- ☐ Machine guards not in place
- ☐ Improper tools
- ☐ Defective tools
- ☐ Improper protective equipment
- ☐ Defective protective equipment
- ☐ Inadequate protective equipment
- ☐ Other: _____

Procedure
- ☐ Unsafe procedures
- ☐ Procedures missing
- ☐ Procedures inadequate
- ☐ Other: _____

Training
- ☐ Employee(s) lack training
- ☐ Employee(s) needs training
- ☐ Other: _____

Supervision
- ☐ Procedures not enforced
- ☐ Use of protective equipment not enforced
- ☐ Use of proper equipment not enforced
- ☐ Other: _____

Worker
- ☐ Horseplay, unsafe behavior
- ☐ Short cuts, carelessness
- ☐ Distracted, inattentive
- ☐ Other

Environment
- ☐ Arrangement of equipment, workflow, tools
- ☐ Poor housekeeping
- ☐ Inadequate lighting

Environment
- ☐ Inadequate ventilation
- ☐ Signs – inadequate signs or other warnings
- ☐ Walking surface

Describe steps recommended or taken to prevent a recurrence:

List any damaged employer property:

Was the event caused by a third-party? ☐ No ☐ Yes, complete below

☐ Auto accident ☐ Rented or leased equipment ☐ Off-site activity ☐ Conference or seminar ☐ Construction area

Name and Address of third-party:

Description of involvement:

Other information:

Photographs taken? ☐ No ☐ Yes, by whom: _____

Police or Fire called? ☐ No ☐ Yes, by whom: _____

Evidence preserved (contact safety or risk management)? ☐ No ☐ Yes, by whom: _____

Completed by (print name): _____ Phone: _____

Signature: _____ Date: _____

☐ **Mark if attachments are included**