HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT

SUPERVISOR'S INCIDENT INVESTIGATION REPORT

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)

_____

Were 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(es) and on the line provided specify the location by indicating LF for Left, RT for Right, BO for Both, FR for Front and BA for Back.)

☐ Head/Skull___	☐ Arm___	☐ Leg___	☐ Heart	☐ Back, Upper___
☐ Nose___	☐ Elbow___	☐ Hip___	☐ Chest	☐ Back, Mid___
☐ Ear___	☐ Shoulder___	☐ Foot___	☐ Lung___	☐ Back, Lower___
☐ Tooth___	☐ Finger___	☐ Knee___	☐ Abdomen___	☐ Neck___
☐ Mouth___	☐ Wrist___	☐ Toe___	Mental Trauma ☐	☐ Other_____
☐ Eye	☐ Hand			

Nature of Injury: (Check appropriate box)

☐ Irritation/inflammation	☐ Strain/Sprain	☐ Emotional Stress
☐ Trauma/Contusion (Bruise)	☐ Fracture	☐ Exposure (to what): _____
☐ Puncture/Laceration	☐ Repetitive Motion	☐ Other: _____
☐ Abrasion	☐ Bite	

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

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

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

☐ Behavior	☐ Equipment/Tools	☐ Material	☐ Other: _____
☐ Objects	☐ Environment	☐ Person	

CORRECTIVE ACTION

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:

☐ Enforce safety procedures	☐ Update or revise procedures
☐ Provide more complete job instruction	☐ Submit work order to correct unsafe condition
☐ Provide personal protective equipment	• Date work order submitted: _____
	☐ Other: _____

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

Prepared by _____ _____
Signature Print Name

Site_____ Date_____

Forward completed form to:
Director of Risk Management
Hal Longan

Form #103 (Revised 8/1/2016)