

SUPERVISOR'S REPORT OF ACCIDENT

Employee Name: _____ Date and Time of Accident: _____

Date Injury Reported: _____ Injury first reported to whom: _____

Loss of Time: Yes/No _____ If Yes, First Day of Lost Time: _____ Anticipated Date of Return to Work: _____

Name of Witness: _____

Did Employee seek medical treatment? Yes No If yes: First Aid , Medical Clinical (Name) _____

Did Employee miss work? Yes No If yes, last date of work _____

Has the Employee returned to work? Yes No Date _____

SUPERVISOR'S INVESTIGATION AND STATEMENT (SUPERVISOR COMPLETES):

SUPERVISOR After the investigation, explain in detail how the injury/illness occurred and the specific activity being performed:

What was the injury, illness or exposure

INITIAL CAUSE	CONTRIBUTING FACTORS AND ACTIVITIES	PREVENTIVE ACTIONS
<input type="checkbox"/> Struck by or against object (indicate) <input type="checkbox"/> Caught in/under/ between <input type="checkbox"/> Fall / Slip / Trip <input type="checkbox"/> Wet Floor <input type="checkbox"/> Snow/Ice <input type="checkbox"/> Cords <input type="checkbox"/> Pallets <input type="checkbox"/> Material handling or lifting <input type="checkbox"/> Repetitive motion <input type="checkbox"/> Chemical exposure <input type="checkbox"/> Body fluid exposure <input type="checkbox"/> Other, Explain _____ _____ _____	<p>Equipment</p> <input type="checkbox"/> Equipment failure <input type="checkbox"/> Equipment unavailable <input type="checkbox"/> Improper equipment or material used for job	<p>Employee</p> <input type="checkbox"/> Physically not able to do work <input type="checkbox"/> Employee fatigue <input type="checkbox"/> Unbalanced or poor position or motion <input type="checkbox"/> Incorrect procedures used for task <input type="checkbox"/> Other unsafe practice
	<p>Personal protective equipment</p> <input type="checkbox"/> Not worn <input type="checkbox"/> Not readily available <input type="checkbox"/> Not adequate for the task <input type="checkbox"/> Personal protective equipment failure	<p>Assistance</p> <input type="checkbox"/> Difficult to perform task without help <input type="checkbox"/> Safety features or devices not readily available <input type="checkbox"/> Assistive devices not used
	<p>Training/Experience</p> <input type="checkbox"/> Lack of training <input type="checkbox"/> Safety training provided, not followed <input type="checkbox"/> New task for employee or lack of experience	<p>Lack of policy/procedure</p> <input type="checkbox"/> Lack of policy/procedure <input type="checkbox"/> Other (explain) _____ _____ _____
	<p>Work Area</p> <input type="checkbox"/> Work area set up improperly <input type="checkbox"/> Inadequate lighting or noise issues <input type="checkbox"/> Housekeeping issues <input type="checkbox"/> Environmental factors (rain, wind, temp. etc) <input type="checkbox"/> Ventilation issues <input type="checkbox"/> Ergonomic factors	<p>SUPERVISOR WILL:</p> <input type="checkbox"/> Develop/revise safety procedures and update Plan <input type="checkbox"/> Request ergonomic evaluation <input type="checkbox"/> Order new equipment <input type="checkbox"/> Order new personal protective equipment <input type="checkbox"/> Remove equipment from use and repair/replace <input type="checkbox"/> Schedule preventive maintenance <input type="checkbox"/> Will retrain employee before task is re-assigned. <input type="checkbox"/> Perform on-site review of work activity, update care plan. <input type="checkbox"/> Reconfigure work area <input type="checkbox"/> Communicate corrective actions to others in job category. <input type="checkbox"/> Other _____
	<p>Use additional pages as needed</p>	<p>Preventive actions will be completed by: Name: _____ Expected date of completion: _____</p>

Does the employee have other employment? (Yes/No) If Yes, where? _____

Contact Person: _____ Phone #: _____

Hours/Week: _____ Weekly Wage: _____

Supervisor Signature: _____ Date: _____