SUPERVISOR INCIDENT REPORT

INJURED WORKER INFORMATION …. EMPLOYEE – STUDENT NURSE – CARPENTRY - INTERN

Name: _____Job Title: _____

Regular Employee? ☐ Yes ☐ No If No, Explain: _____

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

Has the injured worker 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

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*

Injured Worker: ☐ Stayed on Job ☐ Went Home ☐ Went to Physician/Clinic ☐ Other

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

_____

Were pictures taken? ☐ Yes ☐ No If yes, please include them with this form.

Describe how the injury occurred: (Example: injured worker 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 LT 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 boxes.)

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

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

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

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

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

Prepared by _____ _____
(Signature) (Please Print Name)

Title/Site_____ Date _____

Forward completed form to:
Human Resources