SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT

EMPLOYED BY _____

ADDRESS WHERE ACCIDENT OCCURRED _____

NAME OF INJURED _____ LENGTH OF SERVICE _____

DATE OF ACCIDENT _____ TIME _____ DEPARTMENT _____

OCCUPATION WHEN INJURED _____

DEPARTMENT WHERE INJURY OCCURRED _____

EXACT NATURE OF INJURY _____

_____

HOW DID THE INCIDENT OCCUR? _____

_____

_____

CAUSE OF ACCIDENT:

UNSAFE CONDITIONS _____

NOT USING SAFE APPAREL _____

VIOLATION OF SAFETY RULES _____

DESCRIBE _____

_____

WERE PROPER SAFETY APPLIANCES BEING USED? _____

GIVE DETAILS _____

_____

WAS INJURED INSTRUCTED IN SAFE METHOD TO DO THE JOB? _____

_____

IS INJURY A REPEATER? _____ LOST TIME? _____

WHAT CAN BE DONE TO PREVENT A SIMILAR ACCIDENT? _____

_____

WITNESS (IF ANY) _____

_____

_____

DATE OF THIS REPORT _____ _____

DEPARTMENT SUPERVISORS SIGNATURE

Incident Investigation Report

FOR RECORDKEEPERS USE ONLY **Classification:** **(Check all that apply)**	☐ **Near Miss** ☐ **First Aid** ☐ **Medical Treatment (beyond First Aid)**	☐ **Restricted Duty** ☐ **Lost Workday** ☐ **Property Damage**

Date of Report _____ Date of Incident _____

Employee Name _____ Supervisor at Time of Accident _____

Employee Number _____ Supervisor Completing This Report _____

Present Position _____ Witnesses _____

Hire Date _____ Length of Time in Position _____

Department _____ Shift _____

Supervisor/Employee – Preliminary Investigation

Where (what body area) are you experiencing pain? Describe the pain (constant or intermittent).

_____

_____

When (specific day & time) did the pain start?

_____

What were you doing when you first noticed the pain (include specific body position when employee first noticed pain)?

_____

_____

_____

_____

How has the pain changed (if at all) since the initial onset?

_____

_____

What caused the pain to change?

_____

_____

Revision _____

Who were you working with at the time you started experiencing pain?

____

____

If there was a delay in reporting, why did you wait to report this problem/pain?

____

____

Have you had this type of problem/pain before? When and what was the cause? Did you receive medical treatment?

____

____

____

____

- -

Stop Here If Injury Is Not Related To Work

Job Task ______________________________________ Location ____

Time First Noticed _______________________ Time Reported ________________________

Date First Noticed _______________________ Date Reported ________________________

Was employee working overtime at the time of the incident? ☐ Yes ☐ No

Did the employee work the day prior to the accident? ☐ Yes ☐ No

How many days in a row had the employee worked: ________________________

What is the employee's first day off (if applicable)? ________________________

What is the employee's last day of work (if lost time)? ________________________

What was the task being performed?

____

____

____

Type of Injury _____ Location of Injury _____ Right or Left _____

Accident was reported to _____

List of Equipment, materials, chemicals, etc. the employee was using at the time of the incident:

_____

_____

_____

_____

Who was the employee working with at the time of the incident?

_____

Protective equipment worn at the time of the incident: _____

Employee received treatment from: _____

Date of Treatment _____

Medical Provider has been selected by _____

Employee has been evaluated by _____

Date of Evaluation _____

Is the condition related to cumulative exposure? □ Yes □ No

Has another employee been exposed to any body fluids? □ Yes □ No

Comments:

_____

_____

_____

_____

_____ _____

Employee Signature & Date Supervisor Signature & Date

Revision _____

Employee First Report of Injury/Incident

(To be Completed by Employer)

Date _____ Time _____

Name _____ Date of Birth _____

Address _____ Phone _____

Department _____

Job Title/Machine Number at Time of Incident _____

Time First Noticed _____ Time Reported _____

Date First Noticed _____ Date Reported _____

Supervisor _____

Exact Location of Incident _____

Describe the Injury _____

_____

_____

In your own words, describe HOW the incident occurred _____

_____

_____

_____

Specify WHICH body part(s) are injured (mark on drawing to the right)

_____

_____

_____

Who were you working with/near at the time of the incident?

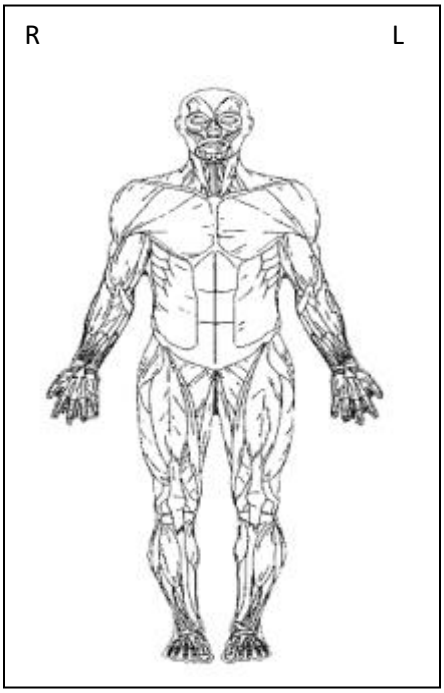
_____

_____

What PPE were you using? _____

_____

_____



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How could this incident have been prevented? _____

_____

_____

_____

Have you ever had this, or a similar problem before? When? What was the cause?

_____

_____

_____

_____

Your Physician/Health Care Provider _____

Address _____

Have you treated with any other physician? Who? _____

Address _____

I certify this is a true and correct statement.

Employee Name _____

Employee Signature _____

Date _____

Witness/Co-Worker Statement

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Employee Signature & Date Supervisor Signature & Date

_____ _____

Employee Name (Printed) Supervisor Name (Printed)

_____ _____

Employee Signature & Date Supervisor Signature & Date

_____ _____

Employee Name (Printed) Supervisor Name (Printed)

Revision _____

Supervisors Description of Events/Statement

Describe in detail how the injury or illness occurred (after completion of your investigation). Please identify specific machine numbers, weights, and frequencies of lifts or actions, distances or comments from co-workers. Is there evidence of a pre-existing injury or illness? Describe what the employee reported.

Root Cause Analysis

Incident /Initial Problem (Root Cause Analysis of Work-Related Incidents)

Event that caused this accident or injury to occur. (Finding of Root Cause)

1) _____

2) _____

3) _____

4) _____

5) _____

Was there a second event that caused this accident or injury to occur?

1) _____

2) _____

3) _____

4) _____

5) _____

Was there a third event that caused this accident or injury to occur?

1) _____

2) _____

3) _____

4) _____

5) _____

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Corrective Action

What actions will be (or have been) taken to prevent this type of event from occurring again?

_____

_____

_____

_____

_____

What will be (or has been) done? _____

_____

_____

_____

_____

_____

Who is going to do it? _____

Assigned to _____ Expected Completion Date _____

Were any plant rules violated? □ Yes □ No

Review/Approvals

Supervisor _____ Date & Time _____

EHS _____ Date & Time _____

Manufacturing Mgr. _____ Date & Time _____

Operations Mgr. _____ Date & Time _____

(Return original to the Benefits Administrator after approval. Maintain a copy for your reference.)

Revision _____