

SUPERVISOR ACCIDENT INVESTIGATION REPORT

(To be completed by the Supervisor with employee input)

Today's Date:	Date/Time of Injury:
Injured Employee:	Occupation:
Department:	Supervisor:

MEDICAL AND LOST TIME STATUS

<input type="checkbox"/> Lost Time	<input type="checkbox"/> Medical Only	<input type="checkbox"/> Report Only
If Lost Time, last day worked:		
If Lost Time, has employee returned to work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, date returned:		
Was first aid administered:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, describe:		
Was employee treated in the emergency room?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was employee hospitalized overnight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ACCIDENT LOCATION

Describe (include building and room, if outside reference land marks to identify location):

ACCIDENT INFORMATION

Please answer the following questions and provide any additional information describing how the accident or injury occurred.

Describe injury (include body part and nature of injury):

What was the employee doing?

Was the employee following established work procedures (e.g., proper lifting)? Describe.

Was the work a routine task or something the employee has not done before or does infrequently?

If the employee was carry materials, what were they, how heavy were they, should the employee have asked for help?

If environmental factors (e.g., temperature, snow/ice, lighting) contributed to the accident, what were they and how did they contribute?

What other conditions in the workplace (e.g., tools, walking surfaces, vehicles) contributed to the accident?

Was personal protective equipment (e.g., goggles, gloves, proper footwear) being used? If not, should it have been?

What employee actions (e.g., rushing, choosing the wrong tool) contributed to the accident?

Additional Information:

WHAT WAS THE PRIMARY CAUSE OF THIS ACCIDENT?

Describe:

Classify

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Unsafe Condition
(an identifiable hazard) | <input type="checkbox"/> Unattentive
(distracted or not paying attention) | <input type="checkbox"/> Repetitive Motion
(an activity performed over and over again) | <input type="checkbox"/> Unsafe Act
(not following established work practices or reasonable conduct) |
|--|---|--|--|

<input type="checkbox"/> Other (Describe)	If other, describe:
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RECOMMENDATIONS FOR PREVENTING SIMILAR ACCIDENTS

Describe:

Is additional training/coaching needed?

Do established work procedures need to be changed?

Is a work order needed to correct a hazard?

HAS RECOMMENDED ACTION BEEN TAKEN?

Yes No

If not, why, when will it be?

Name of Supervisor Completing this Report:

Date:

For all Lost Time Accidents, this Report must also be Reviewed by the Department Head

Name of Department Head Reviewing this Report:

Date: