



Supervisor's Report of Employee Injury & Investigation Form

What type of Incident took place: (check applicable event)

- Notice Only**
- First Aid (no outside medical required- first aid)**
- Injury Requiring Medical Treatment (outside of first aid/paramedic aid)**

Lost Time: YES NO Unknown (Check one)

Venue Name: _____ Unit #: _____

Date of injury: ____/____/____ Time: _____ Department: _____

Name of Injured: _____ Date of birth: ____/____/____

Injured SS#: _____ Injured Address: _____

Phone number of Injured: _____

Supervisor: _____

Witness(s): _____

Was first aid administered? Yes No. If yes, by whom? _____

Was injured sent to (circle one): hospital medical provider home back to work

Method of transportation: _____

Name of Clinic, Hospital, or Medical Provider: _____

Nature and extent of injury:(cut finger on left hand) _____

What job was the employee performing? _____

What object or substance directly caused the injury? _____

Describe in detail how the incident occurred (use separate sheet if needed):

Unsafe Condition

Check any unsafe condition that directly contributed to this incident:

<input type="checkbox"/> Inadequately guarded	<input type="checkbox"/> Defective tool, equipment, or material
<input type="checkbox"/> Unguarded	<input type="checkbox"/> Unsafe construction, design or arrangement
<input type="checkbox"/> Inadequate help	<input type="checkbox"/> Congested area
<input type="checkbox"/> Improperly placed	<input type="checkbox"/> Improperly piled or secured
<input type="checkbox"/> Improper illumination	<input type="checkbox"/> Improper ventilation
<input type="checkbox"/> Improper dress	<input type="checkbox"/> Poor housekeeping
<input type="checkbox"/> Other (describe) _____	

Unsafe Act

Check any unsafe act(s), which contributed to this incident:

<input type="checkbox"/> Failure to use Personal Protective Equipment	<input type="checkbox"/> Using improper equipment
<input type="checkbox"/> Using defective equipment or tools	<input type="checkbox"/> Unsafe lifting or carrying
<input type="checkbox"/> Using equipment or tools unsafely	<input type="checkbox"/> Failure to give warning
<input type="checkbox"/> Failure to check condition of equipment	<input type="checkbox"/> Horseplay
<input type="checkbox"/> Inattention to surroundings or footing	<input type="checkbox"/> Failure to obtain help
<input type="checkbox"/> Forcing equipment unnecessarily	<input type="checkbox"/> Unsafe loading or placing
<input type="checkbox"/> Using improper equipment	<input type="checkbox"/> Taking unsafe position
<input type="checkbox"/> Making safety devices inoperative	<input type="checkbox"/> Operating without authority
<input type="checkbox"/> Other (describe) _____	

Were there other circumstances that contributed to the incident? If so, what were they?

What corrective action (has been/will be) taken to prevent a similar incident?

Is this incident OSHA recordable? Yes No

Was corrective action completed? Yes No. If yes, when? _____

*An Employee's Statement and Witness Statement(s) should be included with this report and maintained in employee file.

If the injury is OSHA recordable please ensure the event is logged on the OSHA 300 form within 5 days.

**Report all work related injuries to HOTLINE
888-872-5676**

**FOR ALL SERIOUS INJURIES INVOLVING DEATH OR
HOSPITALIZATION CONTACT
JULIAN GRAHAM**