



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**