



SUPERVISOR ACCIDENT INVESTIGATION REPORT

SUPERVISOR REPORT [To be completed by the employee's direct supervisor]		
Date of Accident / /	Employee's Name (First, Last)	
Supervisor Name:	Department / Location:	
Was this the employee's usual occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Describe. Was the employee performing a normal job task? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Describe. ----- Do you have any reason to believe this employee's injury did <i>not</i> occur at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, List the Reasons:	Time in occupation. <input type="checkbox"/> Less than 1 month <input type="checkbox"/> 1 to 5 months <input type="checkbox"/> 6 months to 5 years <input type="checkbox"/> More than 5 years	Treatment. <input type="checkbox"/> First-Aid (In-House) <input type="checkbox"/> Emergency Room (Hospital) <input type="checkbox"/> Clinic or Doctor's Office ----- Name of Clinic or Doctor:

ACCIDENT INVESTIGATION

Accident Sequence

Instructions: Describe in reverse order of occurrence, events preceding the injury and accident. Starting with the injury and moving back in time, reconstruct the sequence of events that led to the injury.

- ① Injury Event
 - ② Accident Event
 - ③ Preceding Event 1
 - ④ Preceding Event 2
 - ⑤ Preceding Event 3
-

Describe the Accident:

Injury Classification

Nature of Injury:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Slip / Fall | <input type="checkbox"/> Struck By | <input type="checkbox"/> Contact with Electrical Current | <input type="checkbox"/> Fall from Elevation |
| <input type="checkbox"/> Strain | <input type="checkbox"/> Puncture | <input type="checkbox"/> Burn | <input type="checkbox"/> Fall from Same Level |
| <input type="checkbox"/> Sprain | <input type="checkbox"/> Caught in/or between | <input type="checkbox"/> Other (describe) | |
| <input type="checkbox"/> Struck Against | <input type="checkbox"/> Overexertion | | |

Type of Injury:

- | | | | | |
|-------------------------------------|---|------------------------------------|--|--|
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Crush Injury | <input type="checkbox"/> Sprain | <input type="checkbox"/> Inhalation | <input type="checkbox"/> Other: (describe) |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Eye - Foreign Body | <input type="checkbox"/> Puncture | <input type="checkbox"/> Dermatitis | |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Fracture | <input type="checkbox"/> Infection | <input type="checkbox"/> Repetitive Motion | |
| <input type="checkbox"/> Contusion | <input type="checkbox"/> Laceration | <input type="checkbox"/> Illness | <input type="checkbox"/> Tendonitis | |

Accident Sketch and/or Photograph(s) (Attach)

Witness(s) Interviews:

(1) Name:
Phone Number:
Statement:

(2) Name:
Phone Number:
Statement:

Casual Factors (Check all factors that contributed to the accident)

- | | |
|---|--|
| <input type="checkbox"/> Unsafe Act | <input type="checkbox"/> Failure to work at a safe speed/pace |
| <input type="checkbox"/> Failure to Follow a Standard Operating Procedure | <input type="checkbox"/> Improper body mechanics (i.e. unsafe lifting technique) |
| <input type="checkbox"/> Failure to Comply with Direction | <input type="checkbox"/> Unsafe work environment or condition |
| <input type="checkbox"/> Hazardous Work Condition | <input type="checkbox"/> Failure to obey safety policy |
| <input type="checkbox"/> Failure to use Personal Protective Equipment | <input type="checkbox"/> Inadequate training |
| <input type="checkbox"/> Improper use of Equipment and/or Machinery | <input type="checkbox"/> Horseplay |
| <input type="checkbox"/> Equipment Malfunction | <input type="checkbox"/> Other: |

Comments:

Corrective Actions (corrective actions must be listed for all accidents)

- | | | |
|---|--|------------------------------|
| <input type="checkbox"/> Retrain Employee (s) | <input type="checkbox"/> Use additional Protective Equipment | PROPOSED
COMPLETION DATE: |
| <input type="checkbox"/> Implement a new or revised job procedure | <input type="checkbox"/> Install Machine Guarding | |
| <input type="checkbox"/> Repair or Modify Equipment or Machinery | <input type="checkbox"/> Other. | |
| | (Please Describe Below) | |

Comments:

Supervisor Signature:



Date: