SUPERVISOR'S INCIDENT INVESTIGATION REPORT

This form must be completed by the Supervisor as soon after the incident occurred as possible. This document is used for gathering information for investigating incidents and their causes so corrective action can be implemented to avoid recurrence of future incidents. Every incident should be investigated and the causes corrected.

Name of Employee: _____ **District:** _____ **Dept./Site:** _____

Date of Incident: _____ **Time of Incident:** _____ **Date Incident Reported:** _____

Did employee lose time from work: YES ☐ NO ☐ **Hours lost on day of incident:** _____ **Has employee returned to work?** YES ☐ NO ☐

Employee's job title: _____

PLEASE PROVIDE SPECIFIC INFORMATION TO THE STATEMENTS BELOW. YOUR OPINION MAY HELP US PREVENT FUTURE INCIDENTS.

PLEASE ANSWER THE FOLLOWING STATEMENTS:

1. **WAS THE EMPLOYEE PROPERLY INSTRUCTED ON PERFORMING SAFE AND EFFICIENT JOB TASKS** _____ **YES** ☐ **NO** ☐
2. **DID THE EMPLOYEE VIOLATE ANY JOB INSTRUCTIONS?** _____ **YES** ☐ **NO** ☐
3. **WAS NECESSARY PROTECTIVE EQUIPMENT WORN? (IF APPLICABLE)** _____ **YES** ☐ **NO** ☐
4. **WAS POOR HOUSKEEPING A FACTOR THAT CAUSED THIS INCIDENT TO OCCUR?** _____ **YES** ☐ **NO** ☐
5. **WAS HORSEPLAY A FACTOR IN CAUSING THIS INCIDENT?** _____ **YES** ☐ **NO** ☐
6. **WAS THE INCIDENT CAUSED BY SOMETHING THAT NEEDED REPAIRS?** _____ **YES** ☐ **NO** ☐
7. **WAS THERE A GUARD (IF APPROPRIATE) ON THE EQUIPMENT?** _____ **YES** ☐ **NO** ☐
8. **WAS THERE ANY SPECIFIC PERSONAL ITEMS THAT CONTRIBUTED TO THE INCIDENT?** _____ **YES** ☐ **NO** ☐
9. **WAS THE INCIDENT CAUSED BY AN UNSAFE ACT?** _____ **YES** ☐ **NO** ☐
10. **DID THE EMPLOYEE REPORT THE INCIDENT TO THE SUPERVISOR IMMEDIATELY?** _____ **YES** ☐ **NO** ☐

HOW DID THE INCIDENT OCCUR: (Describe what the employee was doing at the time of the incident, what happened, who was involved) _____

_____

_____

INCIDENT LOCATION: _____

LIST INJURED BODY PARTS: _____

LIST PROPERTY DAMAGE, IF ANY: _____

_____

WITNESS NAMES AND CONTACT INFORMATION: _____

_____

UNSAFE CONDITIONS: (Was unguarded or unsafe condition of machinery, equipment, building or premises involved? If yes, please preserve the evidence)

_____

ACTIONS TAKEN: (After the incident, what did the employer do to correct the conditions that caused the incident?) _____

_____

_____

_____

ADDITIONAL INVESTIGATION NEEDED? YES ☐ NO ☐ **ADDITIONAL TRAINING OR EQUIPMENT NEEDED?** YES ☐ NO ☐

MEDICAL CARE: Did the employee go to the Doctor or Hospital? YES ☐ NO ☐

Submitted By: _____ **Date:** _____

(Please Scan This Document to the Districts Workers' Compensation Representative Immediately)