SUPERVISOR AND/OR SAFETY INVESTIGATION REPORT

Investigator___________________________ Title_________________ Department__________________________________
Date/Time incident occurred_____________________Date/Time incident reported__________________________________
Reported by___________________________ Reported to whom____
name/position name/position

SEVERITY POTENTIAL
____MAJOR ____SERIOUS ____MINOR

PROBABLE RECURRENCE
____FREQUENT ____OCCASIONAL ____RARE

SEVERITY OF INJURY
____FIRST AID ____MEDICAL ____LOST WORK DAYS

CAUSE: (check contributing factors, if applicable)

INCIDENT RESULTED IN
___INJURY ___FATALITY ___PROPERTY DAMAGE

UNSAFE CONDITIONS

___Inadequately guarded
___Unguarded
___Defective tools/equipment/substance
___Unsafe design or construction
___Hazardous arrangement
___Unsafe illumination
___Unsafe ventilation
___Unsafe clothing
___Insufficient instruction

Why did the unsafe condition exist?
____
____
____
____

UNSAFE ACTS

___Operating without authority
___Operating at unsafe speed
___Making safety devices inoperative
___Using unsafe equipment or equipment unsafely
___Unsafe loading, placing, mixing
___Taking unsafe position
___Working on moving or dangerous equipment
___Distraction, teasing, horseplay
___Failure to use personal protective devices

Why was the unsafe act committed?
____
____
____
____

Was the incident avoidable? __Yes __No Is this the same description as the employee's? __Yes __No, Explain:
____

GUIDES TO CORRECTIVE ACTION (To be completed by Supervisor)
Based on the cause checked above, I am taking the following corrective action:

UNSAFE CONDITION
___Remove
___Guard
___Warn
___Supervisor Training

UNSAFE ACT
___Stop the worker
___Study the job
___Instruct (tell-show-try)
___Follow up
___Enforce

IF SUPERVISOR UNABLE TO HANDLE, THEN RECOMMEND TO:
___Own boss
___Safety committee
___Maintenance Department
___Other____

Follow-up: ____
What I am actually doing to prevent similar incidents: ____
____
____
Further recommendations: ____
____
____

____ ____
Supervisor Signature Date

SAFETY COMMITTEE REVIEW BY:

____
Name Position Date

Recommended follow-up?____

____
Name Position Date

EMPLOYEE REPORT OF INCIDENT

THIS FORM **MUST BE COMPLETED BEFORE END OF SHIFT** IN WHICH INCIDENT OCCURRED

NAME **SUPERVISOR NAME**

DEPARTMENT **DATE OF INCIDENT** **___FULL-TIME** **___PART-TIME**

TITLE/SHIFT **HOURS/DAYS OFF** **TIME** **____AM** **____PM** **___ON CALL** **___TEMPORARY**

SS# **WITNESSES**

DESCRIBE INCIDENT, GIVING FULL DETAILS INCLUDE: WHERE? WHAT? WHEN? HOW? WHY?

TO WHOM WAS INCIDENT REPORTED? DATE & TIME REPORTED?

IF DELAYED REPORTING GIVE REASONS.

PART OF BODY

___Head ___Wrist
___Eyes ___Hand
___Nose ___Finger/Thumb
___Mouth ___Hip
___Ear ___Thigh
___Neck ___Knee
___Shoulder ___Leg
___Back, upper ___Ankle
___Back, lower ___Foot
___Chest ___Toes
___Arms ___Internal
(Please indicate ___Left or ___Right)

TYPE OF INJURY/EXPOSURES

___Puncture Wound/Laceration
___Foreign Body
___Sprain/Strain
___Hernia
___Fracture/Dislocation
___Infectious Disease
___Burn/Scald
___Irritations/Dermatitis
___Respiratory
___Tendonitis
___Contusion
___Other

CAUSE

___Fall From Chair or Equipment
___Fall on Same Level
___Fall From Different Level
___Fall From Fainting
___Slip on something
___Spill-Spray
___Slip, no fall
___Struck by Person
___Struck by Equipment
___Struck by Tool or Object
___Pulling
___Pushing
___Lifting
___Reaching or Bending
___Exposure
___Overexertion
___Inhalation
___Heart Attack
___Recurrence of old injury
___Other________________________________

LOCATION

___Parking Lot ___Vehicle
___Production Floor ___Other
___Storage Area
___Supply Room
___Stairway
___Office
___Lunch Room
___Restroom

How could this have been prevented?

TREATMENT

Did you receive First Aid Treatment? ___yes ___no By Whom? ______________________ When? __________________
Were you seen by a Registered Nurse? ___yes ___no Where? _________________________ When?__________________
Were you seen by a Physician? ___yes ___no By Whom? ______________________ When? __________________

EMPLOYEE SIGNATURE **DATE COMPLETED** **TO WHOM REFERRED?** **DATE**