SUPERVISOR ACCIDENT/INVESTIGATION REPORT

FOR EMPLOYEES

TYPE OF INCIDENT: ☐ Injury ☐ Bloodborne ☐ Illness ☐ Other (specify):

EMPLOYEE NAME:	JOB TITLE:
Date and Time of Incident:	Date & Time Reported:
Place of Incident: (address, worksite, etc.):	Did Incident occur during regular scheduled work day/time? ☐ Yes ☐ No (If no, explain.)
Employee Status: ☐ Permanent ☐ Substitute ☐ Volunteer	

DESCRIPTION

Explain how the accident/exposure occurred? (object, activity or substance involved?)

Were unsafe acts involved? ☐ No ☐ Yes (If yes, explain.)

Were unsafe conditions present? ☐ No ☐ Yes (If yes, explain.)

Were there other contributing factors (i.e., hazards, pre-existing injury) ☐ No ☐ Yes (If yes, explain.)

Was the accident caused by anyone not on employer's payroll? ☐ No ☐ Yes (If yes, explain.)

List Witnesses Below (names, titles & how to contact them)

_____

INJURY: ***CALL ADMINISTRATION OFFICE IMMEDIATELY IF TIME LOST OR MEDICAL TREATMENT REQUIRED***

Specify body part(s) injured/exposed & type of injury/exposure (e.g., back strain, blood in right eye, broken left ring finger):

Was personal protective equipment required? ☐ No ☐ Yes Available? ☐ No ☐ Yes Used? ☐ No ☐ Yes

Describe actions and/or personal protective equipment used

Was first aid given? ☐No ☐Yes (If yes, who gave first aid?)	Was medical treatment given? ☐ No ☐Yes If YES, was an SIF2 form completed? ☐ No ☐Yes Was there any lost time from work? ☐ No ☐Yes

CORRECTIVE ACTION

Corrective action to be taken for unsafe act (e.g., discipline, training).

Corrective action to be taken for unsafe condition (immediate & long term).

Have the unsafe conditions been corrected? ☐ No ☐Yes

What could have been done to prevent this accident/incident?

Other action taken?

DISPOSITION

☐ Sent back to work ☐ First aid required ☐ Sent to doctor ☐Sent to hospital Date & Time left work: am/pm

Comments:

SUPERVISOR SIGNATURE:	DATE OF REPORT:

COMPLETE & FORWARD TO THE ADMINISTRATION OFFICE