SUPERVISOR'S REPORT OF ACCIDENT

(PLEASE READ AND FOLLOW INSTRUCTIONS ON BACK)

EVERY ACCIDENT SHOULD BE INVESTIGATED AND THE CAUSES CORRECTED SO THAT MORE ACCIDENTS WILL NOT OCCUR. DO NOT OVERLOC THE SO-CALLED "UNIMPORTANT" CASES, BECAUSE, EXCEPT FOR "CHANCE" THEY COULD ALSO HAVE BEEN SERIOUS. IT IS ONLY BY THOROUG INVESTIGATION THAT MANY OF THE REAL CAUSES CAN BE DETERMINED AND CORRECTED.

NAME OF EMPLOYEE _____ COMPANY _____ DEPT. _____

DATE OF ACCIDENT _____ TIME _____ DID EMPLOYEE LOSE TIME FROM WORK? YES ☐ NO ☐

HOURS LOST ON DATE OF ACCIDENT _____ HAS EMPLOYEE RETURNED TO WORK? YES ☐ NO ☐

JOB TITLE _____ SERVICE WITH THE COMPANY _____ YEARS IN PRESENT JOB _____

GIVE US YOUR HONEST COMMENTS ON QUESTIONS BELOW. WE ARE NOT TRYING TO BLAME ANYONE. YOUR OPINION MAY HELP US PREVENT ACCIDENT REPETITION.

PLEASE ANSWER THE FOLLOWING:		CHECK "YES" OR "NO"	
1.	WAS INJURED PERSON PROPERLY INSTRUCTED IN SAFE AND EFFICIENT METHODS?	YES ☐	NO ☐
2.	DID INJURED PERSON VIOLATE ANY INSTRUCTIONS?	NO ☐	YES ☐
3.	WAS NECESSARY PROTECTIVE EQUIPMENT WORN? (IF APPLICABLE)	YES ☐	NO ☐
4.	DID POOR HOUSEKEEPING CONTRIBUTE TO INJURY?	NO ☐	YES ☐
5.	DID HORSEPLAY CAUSE THE INJURY?	NO ☐	YES ☐
6.	WAS IT CAUSED BY SOMETHING WHICH NEEDED REPAIRS?	NO ☐	YES ☐
7.	SHOULD A GUARD BE PROVIDED?	NO ☐	YES ☐
8.	DID ANY BODILY DEFECT CONTRIBUTE TO INJURY?	NO ☐	YES ☐
9.	WAS IT CAUSED BY AN UNSAFE ACT?	NO ☐	YES ☐
10.	DID INJURED REPORT THE INJURY TO YOU, THE SUPERVISOR, IMMEDIATELY?	YES ☐	NO ☐

ACCIDENT. (DESCRIBE WHAT INJURED WAS DOING AT TIME OF ACCIDENT, WHAT HAPPENED, WHO WAS INVOLVED, NATURE OF INJURY, PART OF BODY AFFECTED.) _____

WITNESSES' NAMES _____

UNSAFE ACTS. (WHAT DID THE EMPLOYEE OR ANOTHER PERSON DO INCORRECTLY?) _____

UNSAFE CONDITIONS. (WHAT UNGUARDED OR UNSAFE CONDITION OF MACHINERY, EQUIPMENT, BUILDING OR PREMISES WAS INVOLVED?)

ACTIONS TAKEN. (WHAT DID YOU DO TO CORRECT THE CONDITIONS WHICH CAUSED THIS INJURY?) _____

REMEDIES. (WHAT SHOULD YOUR ORGANIZATION DO TO PREVENT OTHER INJURIES LIKE THIS?) _____

MEDICAL CARE. DID EMPLOYEE GO TO DOCTOR OR HOSPITAL? YES ☐ NO ☐ IF YES, COMPLETE THE FOLLOWING

NAME OF DOCTOR OR HOSPITAL _____ DATE OF INITIAL VISIT _____

ADDRESS _____ TELEPHONE NUMBER _____

AS SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS' COMPENSATION? ☐ YES ☐ NO

REASONS WHY _____

REPORT SUBMITTED BY _____ DATE _____

ACCIDENT INVESTIGATION & REVIEW FORM

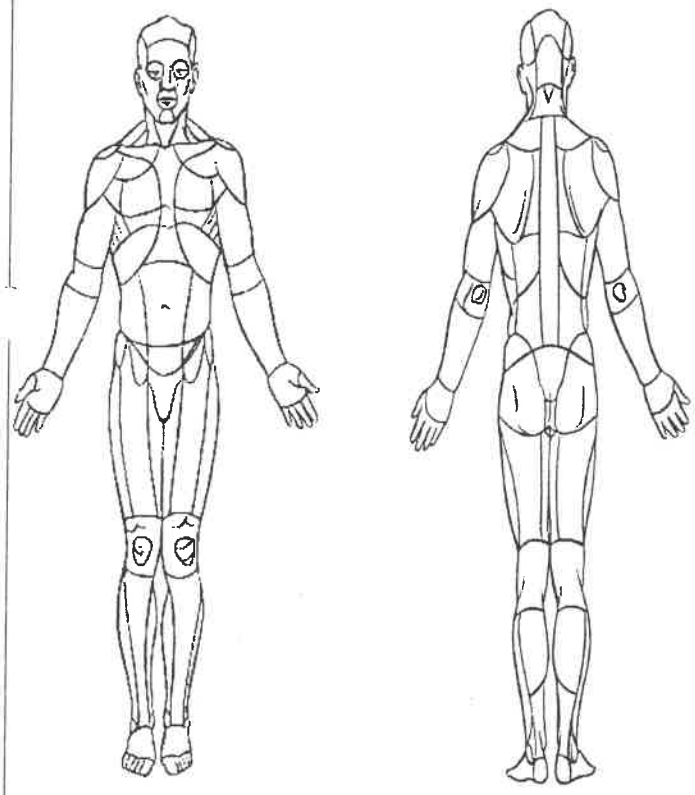
Instructions: Complete this form as soon as possible after an incident or near miss.

This is a report of a: ❑ Death ❑ Lost Time ❑ Dr. Visit Only ❑ First Aid Only ❑ Near Miss	
Date of incident:	This report is made by: ❑ Employee ❑ Supervisor ❑ Team ❑ Other_____ Name of Supervisor:

Step 1: Injured Employee (complete this part for each injured employee)

Name:	Sex: ❑ Male ❑ Female	Age:
Department:	Job title at time of incident:	

Part of body affected: (shade all that apply)



Have employee fill out diagram and sign and date here.

_____

Remind all employees who go to medical provider to bring back a workability report from the doctor.

Nature of injury: (most serious one)
- ❑ Abrasion, scrapes
- ❑ Amputation
- ❑ Broken bone
- ❑ Bruise
- ❑ Burn (heat)
- ❑ Burn (chemical)
- ❑ Concussion (to the head)
- ❑ Crushing Injury
- ❑ Cut, laceration, puncture
- ❑ Hernia
- ❑ Illness
- ❑ Sprain, strain
- ❑ Damage to a body system:
- ❑ Other (Explain below)

This employee works:
- ❑ Regular full time
- ❑ Regular part time
- ❑ Seasonal
- ❑ Temporary

Months with this employer:

Months doing this job:

Step 2: Describe the Incident

Exact location of the incident: (Photos add value)	Exact time:

What part of employee's workday? ❑ Entering or leaving work ❑ Doing normal work activities
❑ During meal period ❑ During break ❑ Working overtime ❑ Other_____

Names of witnesses (if any):

Number of attachments:	Written witness statements:	Photographs:	Maps/Drawings:

What personal protective equipment was being used (if any)?

Describe, step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials, and other important details.

Prior Injuries to this same body part? YES__ NO__
Explain–

Ailments or physical limitations either physically or mentally leading up to this incident?

Description continued on attached sheets, Including time line. ☐

Step 3: Why Did the Incident Happen?

Unsafe workplace conditions: (Check all that apply)
- ❑ Inadequate guard
- ❑ Unguarded hazard
- ❑ Safety device is defective
- ❑ Tool or equipment defective
- ❑ Workstation layout is hazardous
- ❑ Unsafe lighting
- ❑ Unsafe ventilation
- ❑ Lack of needed personal protective equipment
- ❑ Lack of appropriate equipment/tools
- ❑ Unsafe clothing
- ❑ No training or insufficient training
- ❑ Other: _____

Unsafe acts by people: (Check all that apply)
- ❑ Operating without permission
- ❑ Operating at unsafe speed
- ❑ Servicing equipment that has power to it
- ❑ Making a safety device inoperative
- ❑ Using defective equipment
- ❑ Using equipment in an unapproved way
- ❑ Unsafe lifting
- ❑ Taking an unsafe position or posture
- ❑ Distraction, teasing, horseplay
- ❑ Failure to wear personal protective equipment
- ❑ Failure to use the available equipment/tools
- ❑ Other: _____

Why did the unsafe conditions exist?

Why did the unsafe acts occur?

Is there a reward (such as "the job can be done more quickly" or "the product is less likely to be damaged" that may have encouraged the unsafe conditions or acts? ❑ Yes ❑ No
If yes, describe:

Were the unsafe acts or conditions reported prior to the incident? ❑ Yes ❑ No

Have there been similar incidents or near misses prior to this one? ❑ Yes ❑ No

Step 4: How Can Future Incidents Be Prevented?

What changes do you suggest to prevent this incident/near miss from happening again?

❑ Stop this activity ❑ Guard the hazard ❑ Train the employee(s) ❑ Train the supervisor(s)

❑ Redesign task steps ❑ Redesign work station ❑ Write a new policy/rule ❑ Enforce existing policy

❑ Routinely inspect for the hazard ❑ Personal Protective Equipment ❑ Other: _____

What should be (or has been) done to carry out the suggestion(s) checked above?

Description continued on attached sheets: ❑

Step 5: Who Completed and Reviewed This Form? (Please Print)

Written by:	Reviewed By:
Department:	Date: