SUPERVISOR and/or SAFETY INVESTIGATION REPORT

Investigator:		Title	Department	
Date/Time of Incident:		Date/Time Incident Reported:		
Reported by:		Reported to Whom:		

SEVERITY POTENTIAL	PROBABLE RECURRENCE	SEVERITY OF INJURY
☐ Major ☐ Serious ☐ Minor	☐ Frequent ☐ Occasional ☐ Rare	☐ First Aid ☐ Medical ☐ Lost Work Days

INCIDENT RESULTED IN
☐ Injury ☐ Fatality ☐ Property Damage

CAUSE: (check contributing factors, if applicable)

UNSAFE CONDITIONS

- ☐ Inadequately guarded
- ☐ Unguarded
- ☐ Defective tools/equipment/substance
- ☐ Unsafe design or construction
- ☐ Hazardous arrangement
- ☐ Unsafe illumination
- ☐ Unsafe ventilation
- ☐ Unsafe clothing
- ☐ Insufficient instruction

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 did the unsafe condition exist?

_____

_____

_____

_____

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 REVIEWED 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's Name:		
Department:		Date of Incident		Time: ☐ AM ☐ PM
Title:		Employee Works	☐ Full Time ☐ Part Time ☐ On Call ☐ Temporary	
Soc. Sec. #		Shift:		
Witnesses				

Describe incident *(giving full detail including: where, what, when, how, and why)*

To Whom was the incident reported:		Date & Time Reported:
If delayed reporting, give reasons:		

PART OF BODY

- ☐ Head
- ☐ Eyes
- ☐ Nose
- ☐ Mouth
- ☐ Ear
- ☐ Neck
- ☐ Shoulder
- ☐ Back, upper
- ☐ Back, lower
- ☐ Chest
- ☐ Arms
- ☐ Wrist
- ☐ Hand
- ☐ Finger
- ☐ Hip
- ☐ Thigh
- ☐ Knee
- ☐ Leg
- ☐ Ankle
- ☐ Foot
- ☐ Toes
- ☐ 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
- ☐ Production Floor
- ☐ Storage Area _____
- ☐ Supply Room _____
- ☐ Stairway _____
- ☐ Office _____
- ☐ Lunch Room _____
- ☐ Restroom _____
- ☐ Vehicle
- ☐ Other

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:**
To Whom Referred:	**Date:**