SUPERVISOR ACCIDENT INVESTIGATION REPORT

Employee's Name: ________________________________ Job Title/Position:____________________________

Department:________________________________

Name of employee's direct supervisor at the time of the incident:____

Date and time of incident:	Location of incident:

ACCIDENT

Describe how the incident occurred (Attach separate sheet, if necessary)

What was the employee doing at the time of incident? (Attach separate sheet, if necessary)

Was the incident witnessed? ❑ Yes ❑ No If yes, by who?

Describe what you feel was the dominant cause of the accident?

Contributing causes of the accident/incident: (Check all that apply regardless of how remote)

Equipment
❑ Defective tools or machinery
❑ Inadequate, improper, or defective protective equipment
❑ Machine guards missing
❑ Inadequate or defective protective equipment
❑ Inadequate maintenance of items
❑ Other:

Environment
❑ Arrangement of equipment, tools, work flow
❑ Inadequate housekeeping, organization
❑ Adverse Weather
❑ Inadequate lighting or ventilation
❑ Inadequate signage or other forms of warning
❑ Walking surface
❑ Other:

Procedural
❑ Inadequate or missing procedures
❑ Outdated or unsafe procedures
❑ Other:

Training
❑ Insufficient training
❑ Lack of follow-up training
❑ Retraining needed
❑ Other:

Worker
❑ Unsafe behavior or horseplay
❑ Distracted or inattentive
❑ Pre-existing injury or illness
❑ Employee fatigued
❑ Short cuts
❑ Did not have needed skills or experience
❑ Other:

Supervision
❑ Inadequate supervision
❑ Recognized exposure but took no corrective action
❑ Insufficient communication of expectations, policies, procedures, or rules

Injury / Damage

Description of injury:		
Type of Injury: (ie Contusion, Repetitive motion, Burn, Fracture, Sprain)	Body part injured: (ie: Right side of low back, Outside of left calf)	Cause of Injury: (ie Insect bite, Smoke Inhalation, Lifting too much weight)
Describe any property that was damaged in the incident:		

Treatment

Type of medical treatment received:

- ❑ No treatment needed ❑ Medical treatment refused ❑ First Aid only
- ❑ Occupational Med Clinic ❑ Paramedics/EMT ❑ Emergency Room
- ❑ Hospitalized Overnight (OSHA300 log recordable - call YCPARMIA)

Name of Medical provider and facility:____

❑ Check box if this is a pre-designated physician

Did employee return to work after incident? ❑Yes ❑ No	Was the employee given a claim form (DWC1)? ❑Yes ❑ No	If applicable, did the employee sign and return the claim form? ❑ Yes ❑ No ❑ N/A

Prevention

Describe the immediate steps taken to prevent a recurrence:
Describe further steps recommended to prevent a similar accident:
Identify training that the employee has received within the last two years that would apply to this accident:
List any entity policies or procedures that would apply to this accident:

Recovery

Was the event caused by or involve a third party? ❑ No ❑ Yes If yes, identify and describe the 3rd party involvement:

Name & address of third party: ____

Completed by (Print name): ____________________________ Date: ________________

Signature: __________________________________ Phone #: ________________