Supervisor Incident Report

This form must be completed in full by the Director and submitted to the Safety department within 24 hours of the occurrence.

EMPLOYEE INFORMATION

Name: _____Employee ID:_____

Occupation/Title: _____

Has the employee missed time from work beyond normal shift due to injury: Yes ___ No ___

INCIDENT LOCATION INFORMATION

Accident occur on premises: Yes _____ No _____

Department where incident occurred:_____

If not on premises, location where incident occurred: _____

_____

INJURY/ILLNESS INFORMATION

Date Injury Occurred: _____ Time Injury Occurred _____AM _____ PM

Date Injury Reported: _____ Time Injury Reported _____ AM _____ PM

Activity at the Time of Injury *(e.g., assembly, packaging, sweeping, lifting boxes)***:**

_____

What Happened?

_____

_____

_____

_____

_____*(attach separate sheet if necessary)*

Description of Injury: *(if applicable, indicate the specific body part affected including right or left)*

_____

_____ *(attach separate sheet if necessary)*

Witness(es): _____

TREATMENT

Type of Treatment:

_____ On Site (Employee who gave treatment _____)

_____ Clinical/Hospital (Name of Clinic or Hospital _____)

Name of Physician:_____

ANALYSIS

Review Team Members:

_____

_____

State of Mind:	Possible Contributing Factors *(check all that apply)*:		
☐ Hurried	☐ Lack of Procedure / Policy	☐ Procedure Not Followed	☐ No Job Safety Analysis
☐ Frustrated	☐ Lack of Training	☐ No Pre-Use Inspection	☐ Equipment / Tool Issue
☐ Fatigued	☐ Correct Tools Used	☐ Environmental Conditions	☐ Walking / Working Surface
☐ Complacent	☐ Lighting / Visibility	☐ Poor Housekeeping	☐ Ergonomic Issue
☐ None of the Above	☐ Tight Space / Obstructions	☐ In Line of Fire	☐ Eyes Not on Task
	☐ Mind Not on Task	☐ Employee Help Needed	☐ Previous History
	☐ Lack of Supervision	☐ Hazardous Substances	☐ Lack / Improper PPE
	☐ Illness	☐ Miscommunication	☐ No Safety Device Usage

Causes of this Incident? *(consider all contributing factors and states of mind listed above)*

_____

_____

_____

_____

_____

_____

_____*(attach separate sheet if necessary)*

Loss Severity Potential: **High** **Medium** **Low**

Probable Recurrence Rate: **High** **Medium** **Low**

PREVENTION

What Action Has or Will be Taken to Prevent Recurrence?

1. _____

2. _____

3. _____

4. _____ *(attach separate sheet if necessary)*

SIGNATURES

Investigated by: _____ **Date:** _____

Employee *(signature)*: _____ **Date:** _____

Director *(signature):* _____ **Date:** _____

General Manager *(signature):* _____ **Date:** _____