

# SUPERVISOR'S INCIDENT INVESTIGATION REPORT FORM

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## INSTRUCTIONS

This form is to be completed by the supervisor of an employee that has experienced an incident resulting in a serious injury or illness. It shall be completed in a timely manner following an incident, and can also be used to investigate a "near miss" event that could have resulted in an accident or injury. Return completed form to:

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THIS FORM SERVES TO DOCUMENT *select all that apply*

<input type="checkbox"/> DEATH	<input type="checkbox"/> LOST TIME	<input type="checkbox"/> ER / CLINIC TREATMENT	<input type="checkbox"/> FIRST AID ONLY	<input type="checkbox"/> NEAR MISS
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REPORT COMPLETED BY Name and Title

DATE OF INCIDENT

DATE OF REPORT

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## INJURED EMPLOYEE INFORMATION

EMPLOYEE NAME

EMPLOYEE ID

DATE OF BIRTH

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JOB TITLE AT TIME OF INCIDENT

DEPARTMENT

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EMPLOYEE TYPE full- or part-time, contract, etc. Length of time doing this job:

NAME OF OTHER EMPLOYER *if applicable*

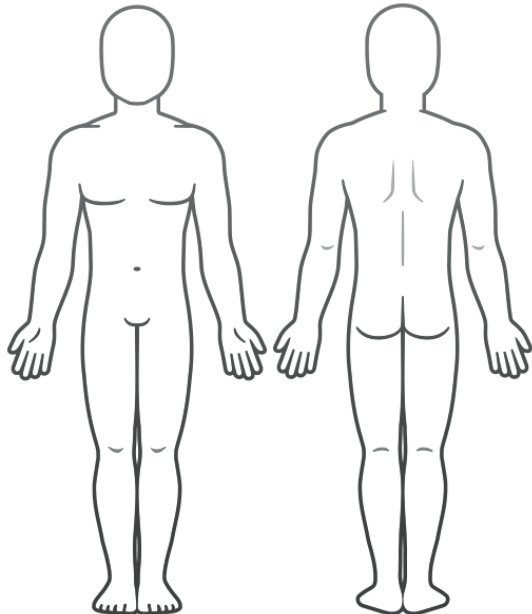
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NATURE OF INJURY *select all that apply*

<input type="checkbox"/> Abrasion, scrapes	<input type="checkbox"/> Amputation	<input type="checkbox"/> Broken Bone	<input type="checkbox"/> Bruise	<input type="checkbox"/> Burn (heat)
<input type="checkbox"/> Burn (chemical)	<input type="checkbox"/> Concussion	<input type="checkbox"/> Crushing Injury	<input type="checkbox"/> Cut, laceration, puncture	
<input type="checkbox"/> Hernia	<input type="checkbox"/> Illness	<input type="checkbox"/> Sprain, strain	<input type="checkbox"/> Damage to body system	
<input type="checkbox"/> Other, describe:				

DESCRIPTION OF INJURY

PART OF BODY AFFECTED *shade all that apply*

	
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# INCIDENT DETAILS

LOCATION

DATE OF INCIDENT

TIME

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What part of the employee's workday did the incident occur?

<input type="checkbox"/>	Entering or leaving work	<input type="checkbox"/>	Doing normal work activities		
<input type="checkbox"/>	During meal period	<input type="checkbox"/>	During break	<input type="checkbox"/>	Working overtime
<input type="checkbox"/>	Other, describe:				

WITNESSES if any

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PROTECTIVE EQUIPMENT List any personal protective equipment used at the time of the incident.

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INCIDENT DESCRIPTION Describe tasks being performed and sequence of events. *Attach additional pages as necessary.*

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ATTACHMENTS List anything to be submitted with this report (forms, witness statements, photographs, maps, drawings, etc.)

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## WHY DID THE INCIDENT OCCUR?

UNSAFE WORKPLACE CONDITIONS *select all that apply*

UNSAFE ACTS BY PEOPLE *select all that apply*

<input type="checkbox"/>	Inadequate guard	<input type="checkbox"/>	Operating without permissions
<input type="checkbox"/>	Unguarded hazard	<input type="checkbox"/>	Operating at unsafe speed
<input type="checkbox"/>	Safety device is defective	<input type="checkbox"/>	Servicing equipment that has power to it
<input type="checkbox"/>	Tool or equipment defective	<input type="checkbox"/>	Making a safety device inoperative
<input type="checkbox"/>	Workstation layout is hazardous	<input type="checkbox"/>	Using defective equipment
<input type="checkbox"/>	Unsafe lighting	<input type="checkbox"/>	Using equipment in an unapproved way
<input type="checkbox"/>	Unsafe ventilation	<input type="checkbox"/>	Unsafe lifting
<input type="checkbox"/>	Lack of needed personal protective equipment	<input type="checkbox"/>	Taking an unsafe position or posture
<input type="checkbox"/>	Lack of appropriate equipment / tools	<input type="checkbox"/>	Distraction, teasing, horseplay
<input type="checkbox"/>	Unsafe clothing	<input type="checkbox"/>	Failure to wear personal protective equipment
<input type="checkbox"/>	No training or insufficient training	<input type="checkbox"/>	Failure to use the available equipment / tools
<input type="checkbox"/>	Other; Describe below:	<input type="checkbox"/>	Other; Describe below:

Why did the unsafe conditions exist?

Why did the unsafe acts occur?

Is there a workplace culture, norm, or expectation that may have encouraged the unsafe conditions or acts?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
If yes, describe:				

Were the unsafe acts or conditions reported prior to the incident?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
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Have there been similar incidents or near misses prior to this one?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
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## HOW CAN FUTURE INCIDENTS BE PREVENTED?

What changes do you suggest to prevent this incident / near miss from happening again? *select all that apply*

<input type="checkbox"/>	Stop this activity	<input type="checkbox"/>	Guard the hazard
<input type="checkbox"/>	Train the employee(s)	<input type="checkbox"/>	Train the supervisor(s)
<input type="checkbox"/>	Redesign task steps	<input type="checkbox"/>	Redesign work station
<input type="checkbox"/>	Write a new policy / rule	<input type="checkbox"/>	Enforce existing policy
<input type="checkbox"/>	Routinely inspect for the hazard	<input type="checkbox"/>	Personal protective equipment
<input type="checkbox"/> Other; Describe below:			

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

REPORT DETAILS

REPORT WRITTEN BY

NAME

TITLE

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DEPARTMENT

DATE

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REPORT REVIEWED BY

NAME

TITLE

--	--

DEPARTMENT

DATE

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INVESTIGATION TEAM MEMBERS

NAME

TITLE


REPORT SUBMITTED BY

NAME

SIGNATURE

DATE

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REPORT RECEIVED BY

NAME

SIGNATURE

DATE

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