SUPERVISOR INCIDENT REPORT FORM

Supervisors use this form for any work related incident or accident.

EMPLOYEE NAME:	GENDER: ❑ M ❑ F	❑ Full Time ❑ Part Time
JOB TITLE:	ENTITY:	
DATE OF HIRE:	DEPARTMENT:	

INVESTIGATION
Interview the Employee and investigate the reported incident and then complete the following:

❑ Check this box if a Declination of Medical Treatment Packet was previously completed for this same incident.

INCIDENT DATE:	TIME OF INCIDENT:	LOCATION OF INCIDENT (building location, department, etc.):
DATE REPORTED:	TIME BEGAN WORK:	

DESCRIPTION OF INCIDENT - Interview the Employee and any witnesses, and determine how the incident occurred and what the employee was doing prior to incident.

DESCRIPTION OF THE INJURY - Body part injured type of injury, etc.

INJURY SOURCE - Investigate and comment on the source of the injury. For example, if the employee has a laceration caused by a tool, examine the tool and indicate whether is appears to be in proper condition, is properly guarded, etc.

HOW INJURY OCCURRED - Investigate how the injury occurred, and determine whether it was caused by an unsafe act or an unsafe condition, or both. Use the sections below to detail the nature of the act(s) or condition(s) that may have caused or contributed to the incident.

UNSAFE ACT – (IF ANY)		PREVENTIVE ACTION(S) TO BE TAKEN
❑ IMPROPER BODY POSITIONING	❑ UNSAFE WORK METHOD	❑ PROVIDE ADDITIONAL TRAINING
❑ HURRIED OR DISTRACTED WORK	❑ UNSAFE USE OF EQUIPMENT	❑ MODIFY/DISCONTINUE WORK PRACTICE
❑ FAILURE TO USE PROPER PERSONAL	❑ IMPROPER LIFTING TECHNIQUE	❑ OTHER:
❑ PROTECTIVE EQUIPMENT (Specify):	❑ OVEREXERTION	

SUPERVISOR'S SIGNATURE

SUPERVISOR:		TITLE:
SIGNATURE:	DATE:	PHONE:

"Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation is guilty of a felony." *This notice approved by the Administrative Director of the Division of Workers' Compensation (CA Labor Code §5401.7)*

Within 7 days of receiving information that a recordable work-related injury or illness has occurred, this form or the Cal/OSHA 301 must be completed.

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes." *Reference: Section 14300.29 (b)(6)-(10)*
When a work-connected fatality or hospitalization occurs, The State of California requires the employer to immediately (within 8 hours) contact the local CalOSHA Area Office to report the incident. *Reference: General Industry Safety Orders Section 342 Reporting Work-Connected Fatalities and Serious Injuries*