**SUPERVISOR'S INCIDENT INVESTIGATION REPORT**

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| **SUPERVISOR'S INCIDENT INVESTIGATION REPORT** | | |  | |
| Every incident, whether serious or minor, is to be investigated. Root causes can be determined and corrected only after thorough investigation. Complete this report and turn it into Human Resources within 48 hours of the incident. | | |
| Employee Name: | | Location of Incident: | | |
| Position: | | Date Incident Occurred: | | |
| Department: | | Time of Incident: A.M. P.M. | | |
| Site Location (if applicable): | | Date Reported to Supervisor: | | |
| **DESCRIPTION OF INCIDENT** | | | | |
| Describe what the incident was and how it occurred. Describe the materials, vehicles, equipment, buildings and people involved. If vehicle accident, provide explanation and diagram on reverse side. | | | | |
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| **UNSAFE ACTS AND/OR HAZARDS INVOLVED IN THE INCIDENT** | | | | **DEFECTIVE EQUIPMENT** |
| What unsafe acts or hazards contributed most directly to this incident? | | | | What equipment/tools affected this incident? |
| [ ] Inadequate training/skills | [ ] Horseplay | | | [ ] Defective equipment/tools |
| [ ] Using improper work methods | [ ] Incorrect instruction/training | | | [ ] Poor ventilation |
| [ ] Operating without authority | [ ] Inadequate physical capability | | | [ ] Improper machine guarding |
| [ ] Not following training or rules | [ ] Failure to secure equipment | | | [ ] Improper equipment maintenance |
| [ ] Improper protective equipment | [ ] Unsafe equipment/tools | | | [ ] Faulty safety device |
| [ ] Other: (describe on reverse) | | | | [ ] Other: (describe on reverse) |
| **List any witnesses and have witnesses complete witness form:** | | | | |
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| **ROOT CAUSE(S) OF INCIDENT:** Describe the most important underlying cause(s) of the incident | | | | |
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| **IF INJURY OR ILLNESS HAS OCCURRED:** [ ] NO INJURY OR ILLNESS HAS OCCURRED | | | | |
| Part of body injured: | | Do you question validity of claim? [ ] Yes [ ] No | | |
| Describe the Illness/Injury: | | | | |
| Treatment received: [ ] Clinic [ ] E.R./Ambulance [ ] On-site 1st Aid [ ] 1st Aid Declined | | | | |
| **RECOMMENDATIONS:** What action(s) should be taken to prevent this type of incident from happening again? | | | | |
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| **Disciplinary action issued to the employee(s) involved? [ ] Yes [ ] No [ ] Not yet decided** | | | | |
| **Supervisor *Signature*: Date:** | | | | |
| **Investigator *Signature* (if not supervisor): Date:** | | | | |

**SUPERVISOR'S INCIDENT INVESTIGATION REPORT (continued)**

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| **UNSAFE ACTS AND/OR HAZARDS:** |
| Please provide details if **"Other"** was checked under this section. |
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| **DEFECTIVE EQUIPMENT** |
| Please provide details if **"Other"** was checked under this section. |
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| **EMPLOYEE OR OTHER Witness**  **Account of Incident** | |  |
| This form is for a witness to complete about a work-related incident.  It should be completed by the witness and turned into Human Resources Department within 48 hours of the incident. | |
| **Witness Name:** | **Date Incident Witnessed:** | |
| **Position/Title:** | **Time Incident Witnessed:** | |
| **Department:** | **Location of Incident:** | |
| **DESCRIPTION OF INCIDENT** | | |
| * Please as best you can describe in detail how the incident occurred (how it happened). * Describe the materials, vehicles, equipment, buildings and people involved. * Describe the type of illness or injury (cut, strain, etc.) and any body part(s) injured. | | |
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| The above information is true and correct to the best of my knowledge. | | |
| **Employee or Other Witness *Signature*: Date:** | | |