



SUPERVISOR'S ACCIDENT INVESTIGATION AND FOLLOW UP

EMPLOYEE : _____

DATE OF INJURY (DOI): ____/____/____ AT ____:____AM/PM

DATE OF HIRE (ORIGINAL): ____/____/____ NUMBER OF YEARS IN CURRENT JOB: _____

JOB TITLE: _____ DEPARTMENT: _____

LOCATION OF INCIDENT: _____

DATE THAT YOU BECAME AWARE OF INCIDENT? ____/____/____

WHEN DID THIS EMPLOYEE START HIS/HER DAY ON THE DOI ? ____:____AM/PM

WHEN DID THIS EMPLOYEE END HIS/HER DAY ON THE DOI ? ____:____AM/PM

WHAT ARE NORMAL WORK DAYS? MON, TUE, WED, THU , FRI , SAT, SUN

WHAT ARE NORMAL WORK HOURS? FROM ____:____AM/PM TO ____:____AM/PM

DID HE/SHE LEAVE EARLY? LOSE ANY TIME FROM WORK ON THE DOI (YES OR NO)? ____

WHAT DID THE EMPLOYEE SAY OR REPORT AS TO HOW HE/SHE WAS INJURED? _____

HOW WAS HE/SHE INJURED? _____

WAS THE RIGHT EQUIP/ TOOL AVAILABLE AND IN GOOD WORKING ORDER? _____

WHY WAS HE/SHE INJURED? _____

DESCRIBE ANY UNSAFE ACTS AND/OR CONDITIONS? _____

HAS EMPLOYEE RECEIVED TRAINING FOR THIS TASK? _____

WAS EMPLOYEE WEARING PPE? IF SO, WHAT PPE? _____

HOW OFTEN DOES EMPLOYEE PERFORM THIS TASK? _____

HOW CAN WE PREVENT THIS INJURY/ACCIDENT FROM HAPPENING AGAIN? _____

WHAT IS THE FOLLOW UP TRAINING/ EDUCATION PLAN FOR THIS EMPLOYEE? _____

WHERE THERE ANY WITNESSES TO THIS INCIDENT (YES OR NO)? _____

HAVE YOU SPOKEN WITH THESE LISTED WITNESSES (YES OR NO)? _____

PLEASE SUPPLY INFORMATION VIA EMAIL OR WRITTEN WITNESS STATEMENT

NAME: _____ PHONE : _____

NAME: _____ PHONE : _____

IF THERE ARE ANY CURRENT PERSONNEL ISSUES OR CONCERNS RE THIS INCIDENT PLEASE INFORM THE WORKERS' COMPENSATION MANAGER ASAP. PLEASE BE SURE TO REPORT ANY CALL OUTS, SICK DAYS REQUESTED AS A RESULT OF THIS INCIDENT TO THE WC MANAGER.

SUPERVISOR SIGNATURE: _____ DATE: _____

PRINTED NAME: _____