

IMMEDIATE SUPERVISOR'S REPORT OF EMPLOYEE INJURY

MUST BE TYPED

Department location & Street address			
Name of injured		SSN#	DOB
		Male <input type="checkbox"/>	Female <input type="checkbox"/>
Nature of injury / illness		Hour a.m. p.m.	Job title (Occupation)
			Date of hire
Who gave first aid, if any?	# Hours worked in last 24 hours	Date of last safety training meeting attended	Was this a normal work assignment or function? Yes <input type="checkbox"/> No <input type="checkbox"/>
Name & address of physician			Was Injured acting in regular line of duty? Yes <input type="checkbox"/> No <input type="checkbox"/>
Date last worked (mm/dd/yy)		Date returned to work (mm/dd/yy)	
If blood / body fluid exposure: Source name			ID number

Describe the accident and department where injury occurred <i>(use additional sheet if necessary)</i>	
Name of Witness & Phone #	Name of Witness & Phone #

IMMEDIATE SUPERVISOR'S EVALUATION

Analysis of Accident Please mark the reason that, in your opinion, caused the accident. In most cases there will be several reasons under both unsafe conditions and unsafe acts contributing to the accident. *Fill out in detail.*

- AN UNSAFE CONDITION EXISTED** *(Check all that apply)*
- | | | |
|---|--|--|
| <input type="checkbox"/> Defective equipment - tools | <input type="checkbox"/> Poor housekeeping | <input type="checkbox"/> Slippery or uneven walking surfaces |
| <input type="checkbox"/> Equipment not properly guarded | <input type="checkbox"/> Faulty layout of facilities | <input type="checkbox"/> Poor working conditions (lights, ventilation, etc.) |
| <input type="checkbox"/> Other (specify) | | |

What have you done to eliminate this condition?

- AN UNSAFE ACT RESULTED FROM** *(Check all that apply)*
- | | | |
|---|--|---|
| <input type="checkbox"/> Lack of training | <input type="checkbox"/> Not using personal safety devices | <input type="checkbox"/> Horseplay |
| <input type="checkbox"/> Not following rules | <input type="checkbox"/> Physical or mental handicap | <input type="checkbox"/> Improper work method |
| <input type="checkbox"/> Haste; chance taking | <input type="checkbox"/> Boredom; inattention | <input type="checkbox"/> Improper body position |
| <input type="checkbox"/> Other (specify) | | |

What have you done to correct this act? *(Person contacted, work request submitted, i.e.)*

Employee's Signature	Date	Dept. Head Signature	Date
Supervisor's Signature	Date	Dept. Safety Representative	Date