



## Supervisor's Accident/Injury Report and Investigation

(To be completed by the immediate supervisor of the injured employee and forwarded to the Director of Safety & Security.)

Employee's name and department \_\_\_\_\_

Employee's job title or occupation \_\_\_\_\_

Employment status: Full time  Part time  Temporary

Pay type: Hourly  Salary  Variable

Date of accident \_\_\_\_\_

Date of investigation \_\_\_\_\_

Location where incident occurred \_\_\_\_\_

Supervisor's Name (Supervisor completing report) \_\_\_\_\_

Wages per hour \_\_\_\_\_

Days worked per week \_\_\_\_\_

Hours worked per day \_\_\_\_\_

Time employee began work on day of injury \_\_\_\_\_

Date & Time employer notified of injury \_\_\_\_\_

By whom \_\_\_\_\_

Has employee missed time from work, beyond their normal shift? Yes  No

If no, expected date to return to work \_\_\_\_\_

If yes, last date worked \_\_\_\_\_

Date disability began \_\_\_\_\_

Did employee return to work [if yes, actual date returned to work]? \_\_\_\_\_

Did the salary continue after the injury? Yes \_\_\_\_\_ No \_\_\_\_\_

Did the employee receive full pay for the date of the injury? Yes \_\_\_\_\_ No \_\_\_\_\_

Injuries [Include what part(s) of body was affected] \_\_\_\_\_

\_\_\_\_\_

Any prior physical disabilities or injuries noted? [If so, what? Will need documentation in personnel file to substantiate.]

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How injury occurred [be specific] \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Chemicals involved? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, list \_\_\_\_\_

\_\_\_\_\_

Tools, vehicle or equipment used at time of injury \_\_\_\_\_

\_\_\_\_\_

Was vehicle or equipment in good working condition? [If no, document problems]

\_\_\_\_\_

\_\_\_\_\_

Was PPE being worn or used? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list \_\_\_\_\_

\_\_\_\_\_

Condition of work area at time of injury \_\_\_\_\_

\_\_\_\_\_

What property was damaged (if any)? \_\_\_\_\_

\_\_\_\_\_

Please indicate which of the following contributed to the illness or incident:

- Improper instruction \_\_\_\_\_
- Lack of training or skill \_\_\_\_\_
- Operating without authority \_\_\_\_\_
- Horseplay \_\_\_\_\_
- Physical or mental impairment \_\_\_\_\_
- Failure to secure \_\_\_\_\_
- Failure to lookout \_\_\_\_\_
- Unsafe position \_\_\_\_\_
- Improper dress \_\_\_\_\_
- Improper protective equipment \_\_\_\_\_
- Unsafe equipment \_\_\_\_\_
- Poor housekeeping \_\_\_\_\_
- Unsafe arrangement or process \_\_\_\_\_
- Poor ventilation \_\_\_\_\_
- Improper guarding \_\_\_\_\_
- Improper maintenance \_\_\_\_\_
- Inoperative safety device \_\_\_\_\_
- Other - explain \_\_\_\_\_

Injured employee's statement [Use additional paper if needed; Have employee sign if possible]

---

---

---

What do you consider the real cause of this accident? [Please do not use the word "careless".]

Supervisor's conclusions: \_\_\_\_\_

---

---

Was the Department of Safety & Security notified? Yes \_\_\_\_ No \_\_\_\_  
If yes, Date \_\_\_\_\_ Time \_\_\_\_\_

Was the Department of Human Resources notified? Yes \_\_\_\_ No \_\_\_\_  
If yes, Date \_\_\_\_\_ Time \_\_\_\_\_

Witnesses [statements, department – use additional paper if needed] \_\_\_\_\_

---

---

Medical treatment given? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, was EMS called? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of medical facility [if applicable] \_\_\_\_\_

Transported by \_\_\_\_\_

---

**Do Not Complete Below**

---

**Department of Safety & Security**

Director or Supervisor's Review: Date \_\_\_\_\_ Time \_\_\_\_\_

Name \_\_\_\_\_

Report sent to CNA: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes: Date: \_\_\_\_\_ Time: \_\_\_\_\_

By whom: \_\_\_\_\_