

# Supervisor's Safety / Investigation Report

Name of Injured Employee & Title			Date of Report
Age	Date of Hire	Department	Name of Supervisor Completing Report & Title
Left      Right <input type="checkbox"/> Head <input type="checkbox"/> Eyes <input type="checkbox"/> Trunk <input type="checkbox"/> Arms	Front      Back <input type="checkbox"/> Hands <input type="checkbox"/> Legs <input type="checkbox"/> Toes <input type="checkbox"/> Internal	Type of Injury <input type="checkbox"/> Wounds <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Hernia <input type="checkbox"/> Fracture	Note: body part location <input type="checkbox"/> Amputation <input type="checkbox"/> Death <input type="checkbox"/> MVA <input type="checkbox"/> Burns <input type="checkbox"/> First Aid Only <input type="checkbox"/> Foreign Body <input type="checkbox"/> Lost Time <input type="checkbox"/> Skin (occupational) <input type="checkbox"/> Due to Delayed Medical treatment
Please mark ALL OF the above that apply to the injury			
Date of Injury	Hour (AM/PM)	Exact Location	Witnesses
Describe Accident: Include the machine, equipment, object or substance involved (all details). Use 2nd page if necessary. Please note if worker was injured before, during, or after regular scheduled work hours.			
CAUSE: Mark basic cause with an "X" Mark contributing cause, if any, with a "/"			
<b>UNSAFE CONDITIONS</b> <input type="checkbox"/> Inadequately guarded <input type="checkbox"/> Unguarded <input type="checkbox"/> Defective Tools, Equipment, or Substance <input type="checkbox"/> Unsafe Design or Construction Hazardous <input type="checkbox"/> Intentional/Not Accidental <input type="checkbox"/> Unsafe Illumination <input type="checkbox"/> Unsafe Ventilation <input type="checkbox"/> Unsafe Clothing <input type="checkbox"/> Insufficient Instruction		<b>UNSAFE ACTS</b> <input type="checkbox"/> Operating without authority <input type="checkbox"/> Operating at unsafe speed <input type="checkbox"/> Making safety devices inoperative <input type="checkbox"/> Using unsafe equipment or equipment unsafely <input type="checkbox"/> Unsafe loading, placing, mixing <input type="checkbox"/> Taking unsafe position <input type="checkbox"/> Working on moving or dangerous equipment <input type="checkbox"/> Distraction, teasing, horse play <input type="checkbox"/> Failure to use personal protective devices	
Any Physical Disabilities that caused or had prior to incident?			
Describe any Previous Disabling Injuries or MVA's, if relevant:			
Based on the Cause marked above, I am taking the following corrective action:			
Unsafe Act <input type="checkbox"/> Stop the worker <input type="checkbox"/> Study the Job <input type="checkbox"/> Instruct <input type="checkbox"/> Follow Up <input type="checkbox"/> Enforce	Unsafe Condition <input type="checkbox"/> Remove <input type="checkbox"/> Guard <input type="checkbox"/> Warn <input type="checkbox"/> Supervisory Training	If Supervisor can't handle, then recommend to: <input type="checkbox"/> Own Boss, or <input type="checkbox"/> Safety Committee, or <input type="checkbox"/> Maintenance Dept., or <input type="checkbox"/> Other	
Signature			