

SUPERVISOR'S INJURY/ILLNESS/INCIDENT REPORT

The supervisor completes this form immediately after being notified of any work-related accident or incident (injury, illness, vehicle accident, property damage, or near-miss incident) and forwards it to the appropriate Occupational Safety Office within two working days. Be specific. Provide enough data that anyone reading the report, who is not familiar with the incident, can understand what happened. For near-miss incidents complete Parts I and IV.

PART I

1. Org./Dept. No.	2. Date of Occurrence	3. Time (Military)	4. Location	5. Date Reported
6. Employee Name:	Social Security No.:	Job Classification:	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female
7. Job Being Done at Time of Incident		8. Experience on This Job or This Equipment (Months)		
		<input type="checkbox"/> Under 3 <input type="checkbox"/> 3 to 12 <input type="checkbox"/> Over 12		
		9. Length of Present Employment (Months)		
		<input type="checkbox"/> Under 3 <input type="checkbox"/> 3 to 12 <input type="checkbox"/> Over 12		

PART II - INJURY/ILLNESS

10. Body Part(s) Involved	<input type="checkbox"/> Left <input type="checkbox"/> Right	11. Nature of Injury/Illness	12. Object/Equip./Substance Inflicting Injury
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PART III - VEHICLE OR PROPERTY DAMAGE

13. Description of Vehicle/Equipment	14. Vehicle Property No.:	15. Nature of Damage	
16. Activity in Progress At Time of Incident	17. Estimated Repair/Replacement Cost	18. Seat Belts Used <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

PART IV - DESCRIPTION OF EVENTS, ANALYSIS OF CAUSES, AND ACTIONS TO PREVENT RECCURANCE

(Mark if additional sheets are attached to accomplish adequate detail.)

19. Describe clearly how the Accident/Incident occurred:			
20. What acts, failures to act and/or conditions, contributed most directly to this accident/incident?			
21. What root causes, basic or fundamental reasons, caused the existence of these failures and/or conditions?			
22. What action has or will be taken to prevent recurrence?			Implementation Date(s):
23. Preventable <input type="checkbox"/> Yes <input type="checkbox"/> No	24. Witnesses 1 _____ 2 _____ 3 _____		
25. Investigating Supervisor:	Phone:	Signature:	Date:
26. Department Manager	Phone:	Signature:	Date:
27. Reviewing Safety Representative	Phone:	Signature:	Date: