

# SUPERVISOR ACCIDENT INVESTIGATION REPORT



**ALL ACCIDENTS, INCIDENTS AND NEAR-MISSES MUST BE REPORTED AND INVESTIGATED AT ONCE.**

DATE INCIDENT REPORTED: \_\_\_\_\_ WHO WAS INCIDENT REPORTED TO?: \_\_\_\_\_  
 WAS C1 COMPLETED? .....  YES       NO

DAY AND DATE OF INCIDENT:	HOUR:	DEPARTMENT/DIVISION:
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EMPLOYEE NAME:	EMPLOYEE JOB TITLE AND ACTIVITY BEING PERFORMED AT TIME OF INCIDENT:
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EXACT LOCATION OF INCIDENT:

DESCRIBE INCIDENT (BE SPECIFIC - ATTACH ADDITIONAL PAGES & DIAGRAM IF NECESSARY):

NAMES AND PHONE NUMBERS OF WITNESSES:

DESCRIBE ANY **UNSAFE CONDITIONS** OR **ACTS** THAT MAY HAVE CONTRIBUTED TO INCIDENT (BE SPECIFIC - ATTACH ADDITIONAL PAGES & DIAGRAM IF NECESSARY):

DO YOU QUESTION THE VALIDITY OF THE CLAIM:

IDENTIFY THE **CAUSE** OF THE INCIDENT (BE SPECIFIC - ATTACH ADDITIONAL PAGES & DIAGRAM IF NECESSARY):

WAS TRAINING REQUIRED TO PERFORM THIS TASK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHEN WAS IT PROVIDED? MONTH ____ YEAR ____	IS PPE PART OF THE SOP'S FOR PERFORMING THIS TASK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT PPE IS REQUIRED?
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WAS EMPLOYEE DISCIPLINED AS A RESULT OF THIS INCIDENT?  YES  NO IF YES, WHAT DISCIPLINE WAS APPLIED?:

WHAT **CORRECTIVE ACTION** HAS BEEN TAKEN?:

PREPARED BY (NAME/TITLE/PHONE NUMBER):	DATE REVIEWED AND SIGNED:
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DIVISION MANAGER SIGNATURE:	DATE REVIEWED AND SIGNED:
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FOLLOW-UP ACTION (TO BE COMPLETED BY ISD ONLY):

**FORWARD COPY TO INSURANCE SERVICES IMMEDIATELY  
 FORWARD ORIGINAL TO INSURANCE SERVICES ONCE ALL REQUIRED SIGNATURES ARE OBTAINED**