***Instructions to Supervisors:*** *Please provide detailed information and complete all sections of this report****.***

***Use F1 key for help-(Editing and content must be enabled)***

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| **1.** Name of Injured Employee:       | **2.** Date Hired:       |
| **3.** Employee’s job title or position:       |
| **4.** Time the employee’s work day began:       |
| **5.** Supervisor’s Name:      | **6.** Dept. /Position:      |
| **7.** How were you informed of employee’s injury?       |
| **8.** Date of employee’s injury:Click here to enter a date. | **9.** Date informed of employee’s injury:Click here to enter a date. | **10.** Date of interview with injured employee: Click here to enter a date. |
| **11.** Witnesses interviewed:       |
| **12.** Facility where injury occurred:       | **13.** Room/Area:       |
| **14.** What task was employee performing when injury occurred?       |
| **15.** Describe nature of injury or illness and part of body affected:   |
| **16.** Injury was caused by contact with what specific object or substance? *(i.e. concrete floor, broken glass, hot pipe, saw blade, chemical vapors, file cabinet, another person, etc.)*       |
| **17.** Describe how the injury/illness occurred:       |
| **18.** List Personal Protective Equipment (PPE) normally required for the task being performed:  Other:      |
| **19.** List PPE employee was wearing at the time of injury:      |
| **20.** Describe hazard that contributed to the injury/illness:       |
| **21.** Describe unsafe actions by employee or others, if any:       |
| **22.** Has employee received safety training relative to this event? [ ] YES[ ] NO[ ] N/A |
| **23.** Which of the following was the leading factor contributing to this incident? -Other:      |
| **24.** What corrective action do you recommend to prevent a recurrence?       |
| **25.** Was medical treatment required beyond basic first aid? [ ]  YES [ ] NO <https://www.osha.gov/recordkeeping/firstaid_list.pdf>  |
| **26.** Has employee been advised to notify employer if further medical treatment is received? [ ] YES [ ] NO |
| **27. If you answered yes on 25-** Has employee been advised to have medical provider complete the return to work checklist and provide to Risk management department for review and approval prior to returning to work? [ ] YES [ ] NO: Comments:      |
| **Supervisor’s Signature:**       | **Date:** Click here to enter a date. |