

## Appendix K – Supervisor's Incident Report

<b>SUPERVISOR'S INCIDENT REPORT</b>				
<input type="checkbox"/> Div. Director		<input type="checkbox"/> Local Safety Specialist		Case or File # _____
<input type="checkbox"/> Safety Director		<input type="checkbox"/> Local Manager		Sex _____ Date of Birth _____
Site _____			<input type="checkbox"/> M	<input type="checkbox"/> F
Specific site location _____ (office #, maintenance area, etc.)				
Employee Name _____		Social Security No. _____		
Home Address _____		City _____		Zip _____
Job Title _____		Date Hired _____	Time on Job _____ (yrs.)	Supervisor's Name _____
Date of Injury/Illness MM / DD / YY	Time Employee began work ____ a.m. ____ p.m.	Time of Injury/Illness ____ a.m. ____ p.m.	Date Reported to Supervisor MM / DD / YY	Employee's Division _____
Place of Injury: On Premises? <input type="checkbox"/> YES <input type="checkbox"/> NO		Address where injury/illness occurred _____ (Street, City, State, Zip Code)		
<b>CLASSIFICATION:</b> <input type="checkbox"/> Major <input type="checkbox"/> Off Work <input type="checkbox"/> Restricted Work <input type="checkbox"/> No Lost Work <input type="checkbox"/> Non-Recordable <input type="checkbox"/> Property Damage Only				
<b>INCIDENT TYPE:</b> <input type="checkbox"/> Fall <input type="checkbox"/> Fire <input type="checkbox"/> Auto Accident <input type="checkbox"/> Improper Lifting <input type="checkbox"/> Electrical Contact <input type="checkbox"/> Other				
Witness to incident: Name _____		Did employee die? _____ yes _____ no		
Phone # _____		If employee died, date of death _____		
If the case involved days away from work or restricted work activity, enter the date the employee returned to work at full capacity _____				
Number of restricted workdays _____		Number of lost workdays _____		
Name all equipment, materials and/or chemicals employee was using when the event occurred (e.g. Acetylene cutting torch, metal plate)				
_____				
Specify activity the employee was engaged in when the event occurred (e.g. cutting metal plate for flooring). Indicate if activity was part of normal job duties.				
_____				
How did the injury or illness occur? Describe the sequence of events and include any objects or substances that directly injured or made the employee ill. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)				
_____				
Describe Injury/Illness and Indicate Body Part Affected (e.g. broken left index finger, dermatitis, etc.)				
_____				
Description of Medical Treatment (e.g. stitches, prescription medication, etc.)				
_____				
Was employee treated by a physician? _____ yes _____ no				
Name of health care provider and address (If hospital was involved, give name and address of hospital)				
_____				
Hospitalized overnight as in-patient? _____ yes _____ no (If emergency room only, mark "no")				
Action taken or that will be taken to prevent recurrence				
_____				
Date of Report _____ Prepared By _____ Position _____				
<b>SIGNATURES</b>				
Supervisor _____		Safety Dir. _____		Site Manger _____
Div. Director _____		Div. Safety Rep. _____		

<b>ACCIDENT BREAKDOWN BY CHARACTERISTIC</b>
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**Nature of Injury**

- Amputation or Enucleation
- Burn or Scald
- Contusion, Bruise
- Cut (Puncture)
- Rash, From Plants
- Rash, Not From Plants (Dermatitis)
- Electric Shock
- Inhalation Injury-Toxic Substance
- Freezing, Frostbite
- Hearing Loss or Impairment
- Heat Exhaustion, Sunstroke
- Hernia or Rupture
- Scratches, Abrasions
- Sprain, Strains
- Fracture
- Multiple Injuries
- Insect Bites
- Needle Puncture
- Other

**Part of Body Affected By Injuries**

- Head
- Eyes (Including Vision)
- Arm(s) (Above Wrist)
- Hand (Including Wrist)
- Finger(s)
- Up Extremity, Multiple Parts
- Abdomen (Including Internal Organs)
- Back (Including Muscles, Spine)
- Chest (Including Internal Organs)
- Hips (Including Pelvic Organs)
- Shoulder(s)
- Trunk, Multiple Parts
- Leg(s) (Above Ankle)
- Foot (Including Ankle)
- Toe(s)
- Low Extremity, Multiple Parts
- Low Extremity, Nec
- Multiple Parts of Body, Severe
- Digestive System
- Respiratory System
- Circulatory System
- Skin
- Other

**Type of Accidents Resulting in Injuries**

- Struck Against Object
- Struck By Flying Object
- Struck By Other Object/Person
- Falls (All Types)
- Caught In, Under, Or Between
- Rubbed Or Abraded By Object
- Bodily Reactions (Sprains, Strains, Rupture, Etc.)
- Contact With Temperature Extremes
- Electrical Shock
- Toxic Materials Exposure
- Noise Exposure
- Disease Exposure
- Repetitive Motion
- Vehicle or Equipment Accident
- Accident Type, Other

**Safety Equipment in Use**

- Hard Hat
- Safety Glasses
- Respirator
- Movable Exhaust Hood
- Ear Protection
- Safety Shoes
- Shoulder Harness
- Reflective Vests
- Flags
- Seat Belts
- Chemical Aprons
- Face shields
- Gloves
- Reflective Triangles
- Warning & Control
- Other Restraining Devices
- Safety equipment, NEC
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