Supervisor's Accident/Incident Investigation Form

Instructions: Supervisors shall use this form to report all reported work-related injuries, illnesses, or first aid events (which could have caused an injury or illness) – no matter how minor. This helps to identify and correct hazards before they cause serious injuries. This form shall be completed by Supervisors upon notice by the employee of a reported on the job injury, illness or "incident".

Type of work related incident reported: ☐ Injury ☐ Illness ☐ First Aid			
Date of incident:	Time of incident:	Other Employees involved in incident: ☐ Yes ☐ No	
Injured Employee Name:		Date of Birth:	Social Security No: xxx-xx-
Department/Occupation:		Telephone Number: ( )	
City:	State:	Zip code:	
(Check one) Male ☐ Female ☐	Was employee given a DWC-1 Claim Form: ☐ Yes ☐ No		
Name body parts injured. (Describe in detail)			
What was the nature of the injury? (Describe in detail)			
Describe fully **how** the incident happened? What was employee doing prior to the incident? What equipment, tools being using? (Describe in detail)			
What was the cause of the incident? (Describe in detail)			
Where did the incident occur? (Location address, department, street, building, public place, etc.)			
Were safety regulations in place and used? If not, what was wrong?			
Were there witnesses? If so, list:			
Recommended preventive action to take in the future to prevent reoccurrence:			
Employee seek medical attention?	☐ Yes ☐ No		
	Doctors Name:		
	Hospital Name:		

Supervisors name _____ Date _____