

Supervisor's Report of Work Related Injury and Illness

General Information:

Name of injured employee:		Today's date:	
Date of incident/injury:	Date reported:	Time of incident/injury:	
School Site/Department:			
Location of injury/incident:			
Employee #	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth:	
Home address:	Phone number where employee can be reached:		
	Job title:		
	Occupation at time of incident:		
	Months/years in occupation:		
	Pre-placement medical evaluation? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
<u>Phase of employee's workday at time of injury or incident</u>			
Break <input type="checkbox"/> Entering or Leaving Facility <input type="checkbox"/> Meal <input type="checkbox"/> Performing Work <input type="checkbox"/> Other _____			
<u>Severity of injury/illness/incident</u>			
Report Only – no treatment <input type="checkbox"/> Physician Treatment <input type="checkbox"/> Light Duty-Temporary Assignment <input type="checkbox"/>			
Lost Workdays-Days Away from Work <input type="checkbox"/> Damage to Equipment, Facility, Etc. over \$500 <input type="checkbox"/>			
Other _____			
<u>Other workers involved or witness to incident (attach eye-witness statements):</u>			

Injury Information (check all that applies):

Accident Type: (what caused physical harm or discomfort)	<input type="checkbox"/> Contact with	<input type="checkbox"/> Caught on	<input type="checkbox"/> Struck by
	<input type="checkbox"/> Electricity	<input type="checkbox"/> Cumulative	<input type="checkbox"/> Student caused
	<input type="checkbox"/> Heat	<input type="checkbox"/> Exposure	<input type="checkbox"/> Over exertion (strain)
	<input type="checkbox"/> Chemicals	<input type="checkbox"/> Fall from height	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Cold	<input type="checkbox"/> Slip/Trip/Fall	
	<input type="checkbox"/> Caught between	<input type="checkbox"/> Stress	
	<input type="checkbox"/> Caught in	<input type="checkbox"/> Struck against	
Nature of Injury:	<input type="checkbox"/> Amputation	<input type="checkbox"/> Fracture	<input type="checkbox"/> Puncture
	<input type="checkbox"/> Bruise or contusion	<input type="checkbox"/> Human bite	<input type="checkbox"/> Repeated trauma
	<input type="checkbox"/> Burn	<input type="checkbox"/> Illness	<input type="checkbox"/> Scratch
	<input type="checkbox"/> Cut or laceration	<input type="checkbox"/> Insect bite	<input type="checkbox"/> Strain or sprain
	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Multiple injuries	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Foreign particle in eye		
Part of Body Affected:	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Eyes: R___ L___	<input type="checkbox"/> Knee: R___ L___
	<input type="checkbox"/> Arms: R___ L___	<input type="checkbox"/> Face	<input type="checkbox"/> Legs: R___ L___
	<input type="checkbox"/> Ankle: R___ L___	<input type="checkbox"/> Feet: R___ L___	<input type="checkbox"/> Shoulder: R___ L___
	<input type="checkbox"/> Back	<input type="checkbox"/> Finger: R___ L___	<input type="checkbox"/> Wrist: R___ L___
	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand: R___ L___	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Elbow: R___ L___	<input type="checkbox"/> Head	

Description of how incident/injury occurred: What happened (if digital pictures are taken list picture reference numbers)?

(Attach additional pages as necessary.)

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Contributing Factors

Workplace conditions that may have contributed to the accident	<input type="checkbox"/> Defective tools or equipment <input type="checkbox"/> Excessive noise <input type="checkbox"/> Failure to warn or secure <input type="checkbox"/> Inadequate guard or protection <input type="checkbox"/> Inadequate lighting	<input type="checkbox"/> Indoor air quality <input type="checkbox"/> Substandard housekeeping <input type="checkbox"/> Trip hazard <input type="checkbox"/> Vapor/Fume exposure <input type="checkbox"/> Other _____
Unsafe work practices that contributed to the accident	<input type="checkbox"/> Failure to use personal-protective equip. <input type="checkbox"/> Horseplay <input type="checkbox"/> Improper body mechanics <input type="checkbox"/> Improper lifting <input type="checkbox"/> Improper loading or placement <input type="checkbox"/> Inattention <input type="checkbox"/> Making safety devices inoperable	<input type="checkbox"/> Operating at improper speed <input type="checkbox"/> Operating equipment without authority <input type="checkbox"/> Rushing <input type="checkbox"/> Servicing equipment in motion <input type="checkbox"/> Was a code of safe practices violated? If so, which one <input type="checkbox"/> Other _____

Incidence Sequence:

List tasks being performed that led to accident. Who was involved in these tasks?	
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Findings / Root Causes (Knowledge, ability, motivation, design, maintenance, environment)

List possible causes or actions that may have contributed to the accident or incident:	
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Corrective Actions Necessary:

What corrective actions need to be taken to prevent another accident (Indicate all that apply)	<input type="checkbox"/> Disciplinary actions <input type="checkbox"/> Improve warning & posting <input type="checkbox"/> Loading or placement training <input type="checkbox"/> Lockout and tagout of energy sources <input type="checkbox"/> Operating procedures posted <input type="checkbox"/> Operator training needed <input type="checkbox"/> Provide better warning <input type="checkbox"/> Replacement or supply safety equipment	<input type="checkbox"/> Safe lifting training <input type="checkbox"/> Specific equipment or task instruction <input type="checkbox"/> Use of necessary personal protective equipment <input type="checkbox"/> Other _____ <input type="checkbox"/> Do these corrective actions need to be made at other sites also?
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Corrective Actions Taken:

Clarify the specific corrective actions taken, who is responsible and when will they be accomplished:	
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Supervisor's Signature: _____ Date: _____

Administrator's Signature: _____ Date: _____

SUPERVISOR'S REPORT OF INJURY

INSTRUCTIONS FOR USE

The form is comprehensive enough to serve as both the Supervisor's Report and the template for an accident investigation. Accident/Incident investigation is a required element for all employers under the Injury and Illness Prevention Program (IIPP). Cal/OSHA notes an employer's investigation procedures, or lack thereof, when following up on complaints or audits. The form has been specifically designed to be able to serve both purposes. It also provides supervisors with a streamlined approach to incident analysis. It is only through thorough incident analysis that effective prevention measures can be implemented.

- The Supervisor's Report of Injury form should be completed whenever an employee reports a work-related incident. Whether the employee requires medical attention is not a prerequisite to completing the form. Even if an employee does not need medical attention, the form should still be completed. The form is designed to capture all relevant elements of an incident, whether comprehensive or simple.
- If the employee does not require medical treatment, the Supervisor's Report is kept on file by the designated person; usually Human Resources (do not send the form to SISC). No further action is required. If an employee does not believe the incident caused an injury that requires medical attention, do not force the employee to seek such treatment.

There is no reason to send an employee to see a physician if not necessary.

There is a common misconception that sending an employee to a physician is required to avoid "liability." There is no such liability being avoided by sending an employee to seek medical treatment when not medically necessary. The Supervisor's Report is the official documentation and is legally sufficient.

- If the incident caused an injury that requires medical attention, provide the employee with the workers' compensation claim form, DWC-1, and follow the claims procedures outlined by SISC I.

In the event an employee reported an incident and originally did not believe medical treatment was necessary, and later believes medical treatment is necessary, the claims process is started at that point. There is no problem, or liability, if this occurs.

If you have any questions about completing the form, or would like assistance in implementing the new form, please contact the SISC Risk Management Services department. Staff are available for in-service, as well as hands-on incident investigation, with district staff.