



SUPERVISOR INCIDENT REPORT

TYPE OF REPORT

	Near Miss	First Aid	Medical Treatment
--	-----------	-----------	-------------------

REPORT COMPLETED BY

Name and Title:

Date Completed:

--	--

INJURED EMPLOYEE INFORMATION

Employee Name:

--

Employee Agency and Job Title:

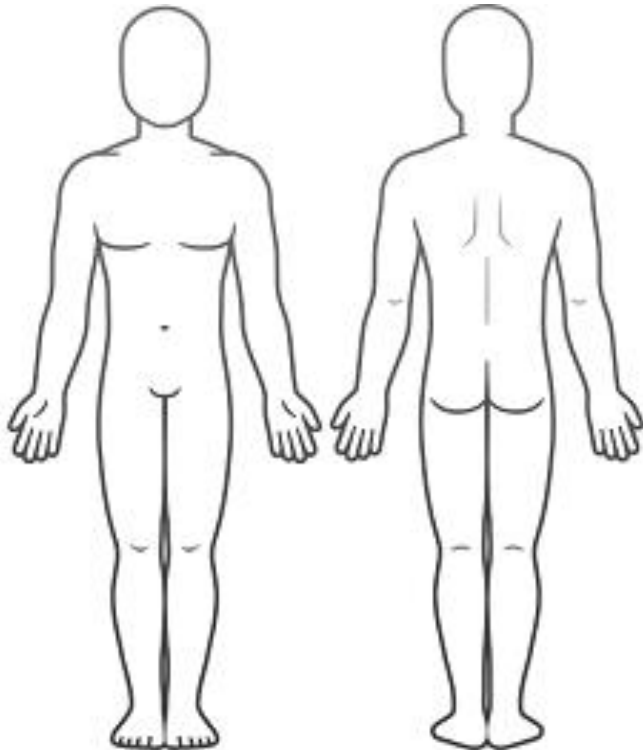
--

INCIDENT INFORMATION

Date of Incident: Time of Incident: Location of Incident:

	<input type="checkbox"/> AM	
	<input type="checkbox"/> PM	

Please circle the part of body injured:



Nature of Injury:

	Abrasion/Scrape/Contusion
	Fracture
	Burn
	Concussion
	Crushing Injury
	Hernia
	Illness
	Sprain/Strain
	Cut/Laceration/Puncture
	Other (please describe below):

Description of Injury/Incident (describe the tasks being performed and sequence of events). Use additional paper if necessary:

Witnesses (if any):

Protective equipment (list any personal protective equipment used at the time of the incident):

Attachments (please list any forms, witness statements, photographs, maps, etc. that will be attached to this form):

WHY DID THE INCIDENT OCCUR?

Unsafe workplace conditions (select all that apply)

Unsafe acts by people (select all that apply)

<input type="checkbox"/>	Inadequate guard	<input type="checkbox"/>	Operating without permission
<input type="checkbox"/>	Unguarded hazard	<input type="checkbox"/>	Operating at unsafe speed
<input type="checkbox"/>	Safety device is defective	<input type="checkbox"/>	Servicing equipment without shutting off power
<input type="checkbox"/>	Tool or equipment is defective	<input type="checkbox"/>	Safety device not in use
<input type="checkbox"/>	Workstation layout is hazardous	<input type="checkbox"/>	Using defective equipment
<input type="checkbox"/>	Unsafe lighting	<input type="checkbox"/>	Using equipment in unsafe way
<input type="checkbox"/>	Unsafe ventilation	<input type="checkbox"/>	Unsafe lifting
<input type="checkbox"/>	Lack of needed personal protective equipment	<input type="checkbox"/>	Using an unsafe posture or position
<input type="checkbox"/>	Lack of appropriate tools/equipment	<input type="checkbox"/>	Distraction/horseplay
<input type="checkbox"/>	Unsafe clothing	<input type="checkbox"/>	Failure to wear personal protective equipment
<input type="checkbox"/>	No training/lack of training	<input type="checkbox"/>	Failure to use the available equipment/tools
<input type="checkbox"/>	Other (please describe)		

Why did the unsafe conditions exist?

Why did the unsafe acts occur?

Were the unsafe acts or conditions reported prior to the incident?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have there been similar incidents or near misses prior to this one?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Supervisor Name (Printed): _____

Supervisor Signature: _____

Date: _____