

Supervisor Incident Analysis Report

Employee Name: _____ Dept.: _____ Job Title: _____

Full-time Date of hire: _____ How long in current position: _____

Part-time Date of incident: _____ Time: _____ am/pm (If date reported is different, explain)

Temporary Date Reported: _____ Time: _____ am/pm _____

Seasonal Witnesses Yes No Names: _____

Other Medical Treatment: Yes No Location of Treatment: _____

Date Notice received from employee: _____ Name of provider/physician: _____

Employee incident report completed in full: Yes No Follow-up: _____

Location of incident (specific area, dept., room): _____

Summary of Incident: _____

Immediate remedy/recommended solution: _____

Please check all that apply						
Injury Type	Body Part			Direct Cause	Object/Issue Involved	
Allergic Reaction	Head	Top	Back	Awkward Position	Box, Barrel, Container	
Body Reaction	Eye(s)	Left	Right	Body Fluid Exposure	Cart – Order fill cart	
Bruise, contusion	Ear(s)	Left	Right	Body Reaction	Chemical _____	
Burn – hot surface	Face	Left	Right	Contact Electrical Outlet	Conveyor	
Burn – chemical	Teeth			Contact Hazardous Substance	Floor, walking surface	
Burn – electrical	Neck	Left	Right	Contact Temperature Extreme	Glass	
Crushing	Shoulder	Left	Right	Caught in, under, between	Housekeeping	
Cut, laceration	Back	Upper	Lower	Combative/horseplay	Knife	
Dermatitis	Middle	Left	Right	Fall from elevation	Ladder	
Dislocation	Arm	Upper	Lower	Fall on same level	Lifting equipment	
Fracture	Elbow	Left	Right	Lifting	Lack of protection equipment	
Foreign body	Wrist	Left	Right	Material handling – lift/carry	Lack of training	
Freezing	Hand	Left	Right	Material handling – push/pull	Medication, alcohol, drugs	
Hearing loss		Front	Back	Motor vehicle accident	Product device	
Heat Street	Finger			Needle stick	Needle	
Infection	Thumb	Left	Right	Overexertion – reach/bend	Opti-pak	
Inflammation/swelling	Torso/chest			Repetitive motion/trauma	Stairway, steps	
Loss of consciousness	Sacrum, coccyx, pelvis			Lifting	Unsafe procedure	
Pain – strain/sprain	Hip/thigh	Left	Right	Moving object	Unknown	
Puncture	Lower leg	Left	Right	Stepped on or in	Work surface/table/bench	
Respiratory	Knee	Left	Right	Struck by/against	Vehicle/forklift/tugger	
Shock – electrical	Ankle	Left	Right		None	
Skin irritation	Foot	Left	Right			

	Toes					
Other	Other			Other		Other
Indirect Causes/Contributing Factors (Please check all that apply)						
Unsafe Acts				Unsafe Conditions		
Driving errors				Blocked egress and/or exits		
Engaging in horseplay				Chemical exposures; physical or airborne		
Failure to use lifting devices				Defective tools, equipment, supplies, materials		
Failure to use material handling aids				Excessive noise		
Failing to use personal protective equipment (PPE)				Fire and explosion hazards		
Improper body posture/mechanics				Hazardous atmospheric conditions: gases/dusts/fumes/vapors/radiation		
Inattention to footing or surroundings				Inadequate guards or safety devices		
Safety devices inoperable				Inadequate warning system		
Not following operating procedure				Inadequate and/or insufficient workspace		
Not reporting defective conditions				Inadequate illumination or ventilation		
Operating equipment without authority/training				Inadequate hazard identification		
Operating equipment at improper speeds				Inadequate training on job task involved		
Rushing or taking shortcuts				Poor housekeeping, congestion in the workplace		
Using equipment improperly				Poor ventilation		
Using defective equipment				Unguarded and/or inadequately guarded hazards		
Suspected us of illegal drugs & alcohol while working				Uninsulated and/or ungrounded electrical system		
Working on energized equipment				Work surface slipper, uneven or unprotected		
Other:				Other:		
Other:				Other:		

No Direct Cause – if an employee reports a symptom with no direct cause, ask the following questions:

1. When did you first notice the symptoms? _____
2. What caused you to notice the symptom? _____
3. New or unusual activities you have performed? _____

Root cause analysis – What do you believe is the root cause of this event? _____

Recommend solution/suggestions: _____

Possible issues or red flags		
Employee filed claim after termination, discipline or layoff		Recent disability, prior to alleged work injury
Investigation/witnesses contradict facts of accident		Hobbies or recreational activity possibly involved
Nature of injury may not correlate with job duties		Employee new to facility (less than 12 months)
Employee refuses to cooperate with investigation		Another party alleges fraud
Injury reported late and/or no witnesses		Performance/attendance issues
Account of accident vague, confusing, or changing		Other:

OSHA reportable Medical Only Lost Time Safety violation Accident review team summary required

Completed by: _____ Date: _____

Title & Dept.: _____ Phone: _____

Administrative Supervisor Signature: _____ Date: _____

Director Signature: _____ Date: _____

Date sent to Risk Management: _____