SUPERVISOR INVESTIGATION REPORT

Part 1 – Medical Dispensary

Crew Member	Job Title	Department / Production
SSN # (last 4 digits) or Company #	Date & Time Reported to Medical Department	
Location of Incident	Date of Injury	Time of Injury
Crew Member Supervisor	Type of Injury	Body Part(s) Affected

DISPOSITION

☐ Treatment Refused				
☐ First Aid Only	Provider			
☐ Emergency Room	Name / Location			
☐ Occ. Health / Urgent Care Ctr.	Name / Location			
☐ Personal Physician	Name / Address			
☐ Other (describe)				
☐ Safety Notified?	Date / Time		Person Notified	
☐ Dept. Head Notified?	Date / Time		Person Notified	

Part 2 – Supervisor

Describe in detail what crew member was doing at the time of injury:

Witness Name(s)	Department	Phone

Check Identifying Contributing Factors

☐ Improper Use of Equipment	☐ Improper Layout of Area	☐ Operating Without Authority
☐ Defective Equipment	☐ Slippery / Uneven Walking Surface	☐ Horseplay
☐ Use of Defective Equipment / Tools	☐ Inadequate Lighting	☐ Altercation
☐ Protective Equipment Not Used	☐ Inadequate Noise Control	☐ Self-inflicted Injury
☐ Inappropriate Personal Protective Equip	☐ Inadequate Ventilation	☐ Weather Temperature
☐ Improper Position or Posture	☐ Absent / Improper Guarding	☐ Insects / Animals in Work Area
☐ Inadequate Training	☐ Improper Storage / Placement of Materials	☐ No Unsafe Act Identified
☐ Inadequate Procedures	☐ Inadequate Housekeeping	☐ No Unsafe Conditions Identified

☐ Other (describe):

Describe Contributing Factors

What action has been taken to prevent a recurrence?

Did you speak with the crew member regarding this incident?	☐ Yes ☐ No	Has crew member returned to work?	☐ Yes ☐ No
Were statements taken?	☐ Yes ☐ No	If not, last day worked?	
Supervisor Completing Report		Phone	Date
Department Head Signature		Phone	Date