SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT/INJURY/ILLNESS
INVESTIGATION OF CAUSES

DIRECTIONS: The Supervisor, **NOT** the employee, must complete this form.

Name of Injured/Ill Employee_____

Job Title _____ Work Phone _____ Home Phone _____

Location of Incident _____

Date of Incident _____ Time of Incident _____ AM./PM Time Began Work _____ AM/PM

To Whom was Incident Reported? _____ Date Reported _____

Unable to work for at least one full day? YES/NO (Circle one) Date Last Worked _____

Still Off? _____ Date Expected to Return to Work _____ Date Returned to Work _____

Nature of Injury/Illness _____

Name of Medical Facility/Physician Seen _____

Describe how Incident Occurred _____

Specific Activity Employee was Performing _____

Equipment/Materials/Chemicals Employee was Using _____

Others Injured or Ill _____ Names of Witnesses _____

Remarks:

SUPERVISORS SIGNATURE: _____ DATE: _____

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ADMINISTRATOR'S REVIEW

ADMINISTRATOR: It is your responsibility to investigate each accident/illness and return this form to Human Resource Services **within two days of any incident**.

Have you thoroughly investigated this incident with the employee or the employee's supervisor? Yes ___☐___ No ___☐___

Has this report been completed fully and accurately? Yes ___☐___No ___☐___ If not, please write your comments here:

What do you feel was the immediate cause of the incident?

Other contributing causes - See footnote for examples (use other side if necessary)

What corrective action has/will be taken to prevent similar incidents? (Thoroughly describe all corrective action taken) Until corrected, what actions have been taken to prevent recurrence in the interim

ADMINISTRATOR'S SIGNATURE_____Date _____

Note: Examples of "Other Contributing Causes" include inadequate instructions given to employee, lack of job skill or training, improper procedures, distractions, no protective equipment, use of wrong tools, poor maintenance on equipment used, poor lighting, excessive noise, heat, cold or other environmental factors.

Any person who makes or causes to be made any knowingly false or fraudulent materials statement or material representation for the purpose of obtaining or denying Workers Compensation benefits or payments is guilty of a felony.

Revised 6/2014

HAS THE WORKERS COMPENSATION SITE LOG BEEN COMPLETED? ☐

DID THE INJURED EMPLOYEE CALL THE SIA NURSE? ☐ ***1-877-742-3467***