

SUPERVISOR

1. Submit the *Employee Incident/Injury Report* as instructed on the report form.
2. Complete an incident investigation **within 5 working days** to determine what, how, and why the incident/injury occurred, and what should or could be done to prevent further occurrences.
3. Submit this original form to Human Resources with a copy to the department head.

SECTION A: EMPLOYEE INTERVIEW

Employee Name			Date of Injury
What do you think caused the incident/injury happened and explain what were you doing at the time of the incident/injury?			
How many hours had you been working prior to the incident/injury?	How long had you been working on this particular task?	Is the task part of your normal duties? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If yes, were you instructed/trained in this task? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
What were you doing in the time prior to the incident/injury?			
Are there any other factors involved (equipment, maintenance, individual)?		What could have been done to prevent this incident from occurring?	
Do you have any other comments or observations?			

SECTION B: ENVIRONMENTAL FACTORS (USE CHECKMARK OR CIRCLE RESPONSES)

What sort of incident/injury occurred (circle one): <i>Cut / Bruise / Burn / Fall / Slip / Trip / Vehicle / Chemical / Stress / Other:</i> _____				
Location where incident occurred?		Standard operating procedures followed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Appropriate safety equipment (PPE) used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Identification of equipment/object involved:		Was equipment in good condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Date equipment was last serviced?	
Lighting adequate? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Confined space? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Surface type (if applicable)	Type of shoes (circle one): <i>Open Toe Boots High Heels</i> <i>Closed Toe Sandals</i> <i>Other</i> _____	
Excessive workload? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Boring/repetitive work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
FALL/ SLIP/TRIP	Height of fall/slip/trip?	Were you: <i>Running / Walking / Climbing / Other</i> _____		
	If stairs, were you going up/down?	Did you fall on your front/back/side?	What (if anything) were you carrying?	
CHEMICALS	Was an MSDS (Material Safety Data Sheet) available? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Disposal / Handling / Storage of chemical product adequate? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
	Items within easy reach? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Ergonomic equipment available? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Equipment used correctly? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Repetitive/Forceful movements? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
MANUAL HANDLING	Action involved: <i>Reaching / Bending / Stooping / Kneeling / Pushing / Pulling / Lifting / Lowering / Carrying</i>		Weight of object?	Height of load?
				Distance carried/moved from/to?
VEHICLE	Traffic conditions:		Weather conditions: <i>Dry / Wet / Foggy / Night / Day</i>	Speed prior to accident?
	Roadway: <i>Intersection / Turning / Driveway / Straight</i>		Travelling to: <i>Work / Lunch / After work / Other</i> _____	
OTHER FACTORS				

SECTION C: INVESTIGATOR’S COMMENTS AND OBSERVATIONS

SECTION D: SUPERVISOR RECOMMENDATIONS

A hierarchy of control should be used to assist with the prevention of future similar injuries. The ‘hierarchy of control’ depicts the most to the least effective methods, as shown in the table below. **This is the most important part of the investigation process!**

RISK CONTROL OPTIONS	ACTION REQUIRED	BY WHOM	BY WHEN
Elimination <i>Do you have to do the task?</i>			
Substitution <i>Is there another way to do the task?</i>			
Engineering <i>Can you engineer a way to make the task safer?</i>			
Administration <i>Can you improve work practices? (e.g. limit time of exposure)</i>			
Personal Protective Equipment (PPE)			

Date feedback provided to employee involved in injury/incident:

Supervisor’s Printed Name/Title	Supervisor’s Signature	Date

SECTION E: ADMINISTRATIVE SERVICES USE ONLY (OTHER SAFETY RECOMMENDATIONS)
