Title: Incident & Investigation Report Form	Reference #: SA012
Section: Safety	Date Effective/Revised: 3/23/2023
Department (s): All	Approved By: Board of Supervisors

Employer Investigation Report

The *Employer Investigation Report* must be completed by the Department Head/Supervisor and turned in to Safety Director within 24 hours of ALL safety incidents/injuries.

1. Employee Name:

2. Employee Address:

3. Date of Birth:

4. ____Male ____ Female

5. Department:

6. Date of Hire:

7. Time employee began work:

8. Date & Time of injury or illness:

9. Location of incident/injury:

10. **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials", "spraying chlorine from hand sprayer", "daily computer key-entry."

11. **What happened?** Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet", "Worker was sprayed with chlorine when gasket broke during replacement", Worker developed soreness in wrist over time."

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12. **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than “hurt’, “pain”, or “sore.” Examples: “strained back”, chemical burn, hand”, “carpal tunnel syndrome.”

13. **What object or substance directly harmed the employee?** Examples: “concrete floor”, “chlorine”, “radial arm saw.” If this question does not apply to the incident, leave it blank.

14. Did the incident/injury occur because of an unsafe act or unsafe condition of equipment?
________ YES ________ NO

Explain:

15. Was there corrective action taken to prevent this incident/injury from happening again?

Explain:

16. Was first aid given? ________ YES ________ NO By whom? ____________________

Explain what was done: ____

17. Was the employee sent/transported to Compass Memorial Healthcare?
________ YES ________ NO

Explain:

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18. Was the employee hospitalized overnight as an in-patient? _____Yes _____No

19. Did the employee miss any days of work? _____Yes _____No
    If Yes, how many days missed: _________

20. Was the employee placed on any restrictions? Yes No

Explain:

21. List names and departments of ALL witnesses (use additional paper if necessary):

Name: Department:

Name: Department:

Name: Department:

Name: Department:

Completed by: Title:

Phone: Date:

SAFTY DEPARTMENT USE ONLY

Case #:

IMWCA Case Manager: