

Supervisor's Injury Investigation Form

Name of Injured Person: _____ Department _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone Number: _____

Date of Injury: ____/____/20____ Time of Injury: _____

(Circle One) Male Female Age: _____ Job title at time of injury: _____

<p>Nature of injury: (check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abrasion, cut, laceration, puncture, scrapes <input type="checkbox"/> Amputation <input type="checkbox"/> Back/Neck <input type="checkbox"/> Broken bone <input type="checkbox"/> Bruise <input type="checkbox"/> Burn (heat) <input type="checkbox"/> Burn (chemical) <input type="checkbox"/> Concussion (to the head) <input type="checkbox"/> Crushing injury <input type="checkbox"/> Exposure (bodily fluids) <input type="checkbox"/> Eye (irritation, scratch, poke, gouge) <input type="checkbox"/> Sprain, strain <input type="checkbox"/> Damage to a body system (nerve, circulatory, etc.) <input type="checkbox"/> Other: _____ 	<p>This employee works:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Regular Full Time <input type="checkbox"/> Regular Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary
<p>Supervisor's Comments(if any):</p> <p>Additional Comments on following sheet <input type="checkbox"/></p>	

Why did the incident happen?

<p>Unsafe workplace conditions: (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Inadequate guard <input type="checkbox"/> Unguarded hazard <input type="checkbox"/> Safety device is defective <input type="checkbox"/> Tool or equipment is defective <input type="checkbox"/> Work area/station is hazardous <input type="checkbox"/> Unsafe lighting <input type="checkbox"/> Lack of needed personal protection <input type="checkbox"/> Lack of appropriate equipment/tools <input type="checkbox"/> No training or insufficient training <input type="checkbox"/> Slippery Conditions <input type="checkbox"/> Other: _____ 	<p>Unsafe acts by people: (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Operating without permission <input type="checkbox"/> Operating at unsafe speed <input type="checkbox"/> Servicing equipment that has power to it <input type="checkbox"/> Making a safety device inoperative <input type="checkbox"/> Using defective equipment <input type="checkbox"/> Using equipment in an unapproved way <input type="checkbox"/> Unsafe lifting <input type="checkbox"/> Taking an unsafe position or posture <input type="checkbox"/> Distraction, teasing, horseplay <input type="checkbox"/> Failure to wear personal protective equipment <input type="checkbox"/> Failure to use the available equipment/tools <input type="checkbox"/> Other: _____
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Is there a reason (such as "the job can be done more quickly") that may have encouraged the unsafe conditions or acts?

____ Yes ____ No If yes, describe: _____

Were the unsafe acts or conditions reported prior to the incident? Yes No

Have there been similar incidents or near misses prior to this one? Yes No

Comments: _____

Supervisor's Signature: _____ Date: _____

Department Head Signature: _____ Date: _____

City of Hickory Injury Report

Return to Risk/Human Resources with Industrial Commission Form 19

*****SUBMIT THIS REPORT WITHIN 24 HOURS FROM TIME OF ACCIDENT/INCIDENT/INJURY*****

Date of Accident: _____ Time of Accident: _____ Date of Hire: _____ Date of Birth: _____

Last Name _____ First Name: _____ Middle Initial: _____

Department: _____ Position: _____

Immediate Supervisor: _____ Supervisor Notified: _____

Date and Time Supervisor Notified: _____ Witnesses: _____

Address of Accident: _____

If inside Building, Location within Building: _____

List Names of any other Co-Workers Injured (Each person must complete a separate report):

Last Name: _____ First Name: _____ MI: _____

Last Name: _____ First Name _____ MI: _____

Did you visit? <input type="checkbox"/> City Nurse <input type="checkbox"/> Doctor <input type="checkbox"/> ER/Urgent Care <input type="checkbox"/> None	Drug Test? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were you exposed to blood other than your own? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Personal Protective Equipment or Safety Equipment Being Used at the time of Injury:

Safety Glasses Respirator Mask Hearing Protection Safety Boots/Shoes Safety Vest Gas Detector Seat Belt
 Hard Hat Gloves Flagging/Signage/Barricades in Place Chaps
 Other (Specify) _____

Describe Fully How Injury Occurred and What Employee Was Doing When Injured:

List Specific Body Part(s) Involved (Example: Right Hand, Left Leg):	Injury Other Than City Co-Worker (citizen, etc):
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Additional Comments (injured co-worker only):

Declaration: I certify that my statements made in this report are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I authorize investigation of all statements made in this report. I understand that false information may be grounds for dismissal. If I was unable to complete this form, I certify I directed the person listed below to complete the form based on my answers.

Coworker Signature: _____ Date: _____

If coworker did not complete this form, explain why:

Who completed the form for the coworker? _____