

### Supervisor's Injury Investigation Form

Name of Injured Person: \_\_\_\_\_ Department \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_

(Choose 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"><li><input type="checkbox"/> Abrasion, cut, laceration, puncture, scrapes</li><li><input type="checkbox"/> Amputation</li><li><input type="checkbox"/> Back/Neck</li><li><input type="checkbox"/> Broken bone</li><li><input type="checkbox"/> Bruise</li><li><input type="checkbox"/> Burn (heat)</li><li><input type="checkbox"/> Burn (chemical)</li><li><input type="checkbox"/> Concussion (to the head)</li><li><input type="checkbox"/> Crushing injury</li><li><input type="checkbox"/> Exposure (bodily fluids)</li><li><input type="checkbox"/> Eye (irritation, scratch, poke, gouge)</li><li><input type="checkbox"/> Sprain, strain</li><li><input type="checkbox"/> Damage to a body system (nerve, circulatory, etc.)</li><li><input type="checkbox"/> Other: _____</li></ul>	<p>This employee works:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Regular Full Time</li><li><input type="checkbox"/> Regular Part Time</li><li><input type="checkbox"/> Seasonal</li><li><input type="checkbox"/> Temporary</li></ul>
<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"><li><input type="checkbox"/> Inadequate guard</li><li><input type="checkbox"/> Unguarded hazard</li><li><input type="checkbox"/> Safety device is defective</li><li><input type="checkbox"/> Tool or equipment is defective</li><li><input type="checkbox"/> Work area/station is hazardous</li><li><input type="checkbox"/> Unsafe lighting</li><li><input type="checkbox"/> Lack of needed personal protection</li><li><input type="checkbox"/> Lack of appropriate equipment/tools</li><li><input type="checkbox"/> No training or insufficient training</li><li><input type="checkbox"/> Slippery Conditions</li><li><input type="checkbox"/> Other: _____</li></ul>	<p>Unsafe acts by people: (Check all that apply)</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Operating without permission</li><li><input type="checkbox"/> Operating at unsafe speed</li><li><input type="checkbox"/> Servicing equipment that has power to it</li><li><input type="checkbox"/> Making a safety device inoperative</li><li><input type="checkbox"/> Using defective equipment</li><li><input type="checkbox"/> Using equipment in an unapproved way</li><li><input type="checkbox"/> Unsafe lifting</li><li><input type="checkbox"/> Taking an unsafe position or posture</li><li><input type="checkbox"/> Distraction, teasing, horseplay</li><li><input type="checkbox"/> Failure to wear personal protective equipment</li><li><input type="checkbox"/> Failure to use the available equipment/tools</li><li><input type="checkbox"/> Other: _____</li></ul>
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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? \_\_\_\_\_