

SUPERVISOR INCIDENT INVESTIGATION REPORT

The purpose of this report is to help prevent similar incidents from recurring. Make this report as accurate and thorough as possible. Remember, always follow-up with the appropriate corrective actions.

Investigation Conducted by: _____ Date: _____

Incident Type: Near Miss Injury Illness

Incident Date: _____ Time: _____ AM/PM

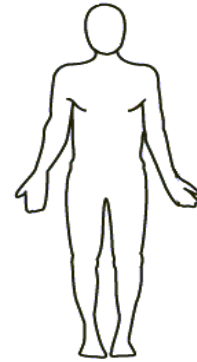
Injured Worker: _____ Department: _____

Occupation: _____ Months on this job: _____

Describe the injury or damage, be specific: _____

Who was nearby? (list names) _____

Where did the incident occur? _____



Circle the body parts

What was the employee doing at the time of injury?

Regular Job Task Specially Assigned Task Unassigned Task

Describe the task. How many days/months/years has the employee been performing this task:

On Break In Transit Other

Describe: _____

Describe how the incident occurred? _____

What equipment was involved? _____

List at least one thing we can do to prevent similar incidents? _____



EMPLOYEE REPORT OF INJURY
(To be completed by the employee only)

The purpose of this report is to help with the claims reporting process. It should be completed and signed by the injured worker.

Date of Injury: _____ Time of Injury: _____ AM/PM

Name: _____ Date of Birth: **Do not answer**

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Job Title/Occupation: _____ Months on this job: _____

Social Security No: **Do not answer** Weekly Salary: **Do not answer**

Supervisor: _____ Phone: _____

When did you report the accident and to who? _____

Do you require medical attention? Yes: _____ No: _____ Maybe: _____

Location of accident (entrance, loading dock, bathroom, etc.): _____

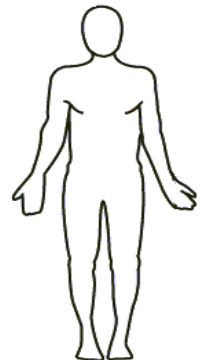
Name of Witness(es): _____

Please describe in detail how the incident occurred and what you were doing when the incident occurred? _____

What did you hurt? What body parts were affected? _____

What is at least one thing we can do to prevent this accident from happening again? _____

Employee Signature: _____ Date: _____



Circle the body parts

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WITNESS INCIDENT REPORT

The purpose of this report is to help prevent similar incidents from recurring. Remember, we are fact finding not fault finding. Please, make this report as accurate and thorough as possible.

Witness Name: _____ Date of Report: _____

Job Title/Occupation: _____ Work Phone: _____

Date of Injury: _____ Time of Injury: _____ AM/PM

Injured Worker: _____

Location of accident (entrance, loading dock, bathroom, etc.): _____

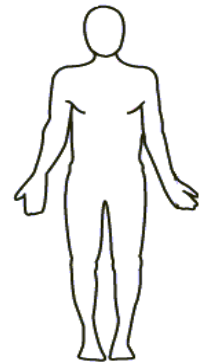
What was the injured worker doing when the incident occurred? _____

How did the incident occur? _____

What body parts were injured? _____

What is at least one thing we can do to prevent this accident from happening again?

Witness Signature: _____ Date: _____



Circle the body parts