SUPERVISOR'S INCIDENT REPORT

This report should be completed for accidents that do not require completion of the Supervisor's Accident Report

NAME OF EMPLOYEE:	DATE OF INCIDENT:	TIME OF INCIDENT:
ADDRESS/LOCATION OF INCIDENT:	TIME BEGAN WORK:	LAST WORKED DATE:
DEPARTMENT:	NAME OF SUPERVISOR:	HRS WORKED THIS WEEK:

WHAT HAPPENED? *(Please be as detailed as possible, if additional space is needed use back of form)* ______________________

WHAT & WHERE WAS THE INJURY? *(i.e. Left knee; Right knee, etc)* ______________________

WERE YOU PAID FOR THE FULL DAY OF INJURY? IF NOT, WHAT TIME WERE YOU SENT HOME? __________

IF DAMAGED PROPERTY, WHAT EQUIPMENT WAS DAMAGED & WHO DID IT BELONG TO? __________

WHAT OTHER CONTROL MEASURES CAN BE TAKEN AND BY WHOM? __________

TYPE OR CAUSE OF INCIDENT:

- **Unsafe Working Conditions** ☐
- **Unsafe Practice** ☐
- **Lack of Knowledge or Training** ☐
- **Caught In or Between** ☐
- **Struck By or Against** ☐
- **Contact with Sharp Object** ☐
- **Slip/Trip/Fall** (on same level) ☐
- **Slip/Trip/Fall** (two or more levels) ☐
- **Strain or Sprain** ☐
- **Exposure to BBP or other** ☐
- **Overexertion and/or lifting** (strain) ☐
- **Other:** __________ ☐

______________________ ______________
INJURED EMPLOYEE'S SIGNATURE **DATE**

______________________ ______________
SUPERVISOR'S SIGNATURE **DATE**

REPORT DISTRIBUTION: ______________________