

Appalachian State University SUPERVISOR INCIDENT INVESTIGATION REPORT

This report to be submitted to ASU Human Resources, Workers' Compensation Administrator, within 24 hours of incident.		
Agency/University:	Date of Incident:	
Employee Name:	Employee Phone #:	
Incident Supervisor:	Supervisor Phone #:	
Incident Classifications (check all that apply)		
<input type="checkbox"/> Near Hit <input type="checkbox"/> Injury <input type="checkbox"/> Fatality <input type="checkbox"/> Property Damage <input type="checkbox"/> Spill <input type="checkbox"/> Possible Blood Borne Pathogen exposure		
Employee required:		
<input type="checkbox"/> First-Aid Only <input type="checkbox"/> Medical treatment and released <input type="checkbox"/> Hospitalized <input type="checkbox"/> Other:		
Employee:		
<input type="checkbox"/> Returned to work no restrictions <input type="checkbox"/> Returned to work with restrictions <input type="checkbox"/> Did not return to work (Lost Days)		
Hazard Types (select one based on origination of injury in this preference order)		
<input type="checkbox"/> Violence or injuries caused by people or animals <input type="checkbox"/> Transportation <input type="checkbox"/> Fires or Explosions <input type="checkbox"/> Slips, Trips, Falls Surface Level <input type="checkbox"/> Fall from Elevation <input type="checkbox"/> Exposure to harmful substances or environment <input type="checkbox"/> Contact with objects or equipment (Struck By, Struck Against, Caught-on, Caught between, Puncture, Cut) <input type="checkbox"/> Over-Exertion (lifting) <input type="checkbox"/> Bodily Motion (reaching, twisting, running) <input type="checkbox"/> Other (List Here):		
Names of Witnesses Interviewed:		
Incident Information		
Describe the specific activity the employee was engaged in and the sequence of events. Include objects or substances that directly injured or made the employee ill. Describe tools, equipment, and PPE in use. Describe property damage. Attach pictures or police reports. Describe the estimated damage to any vehicles or equipment (make, model, ID number, etc.)		
Is the activity part of the employee's normal job? <input type="checkbox"/> Yes <input type="checkbox"/> No	Prior to beginning activity, did the employee review potential hazards/dangers? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date employee last received training for the activity. / /
What was the root cause of the incident? Ask why then ask why again (e.g. Why? The employee slipped on scrap metal. Why? The work area was not cleaned up. Why? The employee was rushing to get a project done and did not take time to clean up the work area.)		
Action taken or will be taken to prevent reoccurrence (If corrective action will occur in the future, provide estimated completion date.)		
I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied. I also acknowledge that I understand that in addition to being disciplined for providing false and/or misleading information up to and including dismissal, I may also be subjected to additional criminal and/or civil liability.		
Supervisor's Name:	Signature	Date of Report: / /
Manager's Name:	Signature	Date Reviewed: / /
Safety Manager Name:	Signature	Date / /
Date Corrective Actions Completed:		



ACCIDENT BREAKDOWN BY CHARACTERISTIC (check all that apply)	
Nature of Injury	Part of Body Affected
<input type="checkbox"/> Amputation or Enucleation <input type="checkbox"/> Assault <input type="checkbox"/> Burn or Scald <input type="checkbox"/> Contusion, Bruise <input type="checkbox"/> Electric Shock <input type="checkbox"/> Eye, Foreign body in <input type="checkbox"/> Fracture, Broken Bone <input type="checkbox"/> Freezing, Frostbite <input type="checkbox"/> Hearing Loss or Impairment <input type="checkbox"/> Heat Exhaustion, Sunstroke <input type="checkbox"/> Hernia or Rupture <input type="checkbox"/> Infection <input type="checkbox"/> Inhalation Injury-Toxic Substance <input type="checkbox"/> Insect Bites <input type="checkbox"/> Laceration (Cut) <input type="checkbox"/> Multiple Injuries <input type="checkbox"/> Needle Puncture <input type="checkbox"/> Rash, From Plants <input type="checkbox"/> Rash, Not From Plants (Dermatitis) <input type="checkbox"/> Scratches, Abrasions <input type="checkbox"/> Sprain, Strains <input type="checkbox"/> Other	<input type="checkbox"/> No Physical Injury <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes (Including Vision) <input type="checkbox"/> Arm(s) (Above Wrist) <input type="checkbox"/> Hand(s) (Including Wrist) <input type="checkbox"/> Finger(s) and Thumb(s) <input type="checkbox"/> Upper Extremity, Multiple Parts (shoulder, arm, forearm, wrist, or hand) <input type="checkbox"/> Abdomen (Including Internal Organs) <input type="checkbox"/> Back (Including Muscles, Spine) <input type="checkbox"/> Chest (Including Internal Organs) <input type="checkbox"/> Hips (Including Pelvic Organs) <input type="checkbox"/> Shoulder(s) <input type="checkbox"/> Trunk, Multiple Parts <input type="checkbox"/> Leg(s) (Above Ankle) <input type="checkbox"/> Foot (Including Ankle) <input type="checkbox"/> Toes <input type="checkbox"/> Lower Extremity, Multiple Parts (from the hip to the toes) <input type="checkbox"/> Multiple Parts of Body, Severe <input type="checkbox"/> Digestive System <input type="checkbox"/> Respiratory System <input type="checkbox"/> Circulatory System <input type="checkbox"/> Skin <input type="checkbox"/> Other
Type of Accidents	Safety Equipment in Use
<input type="checkbox"/> Bodily Reactions (Sprains, Strains, Rupture, Etc.) <input type="checkbox"/> Caught In, Under, Or Between <input type="checkbox"/> Contact With Temperature Extremes (Fire, Cold) <input type="checkbox"/> Disease Exposure <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Falls (All Types) <input type="checkbox"/> Noise Exposure <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Rubbed Or Abraded By Object <input type="checkbox"/> Struck Against Object <input type="checkbox"/> Struck by Flying Object <input type="checkbox"/> Struck by Other Object/Person <input type="checkbox"/> Toxic Materials Exposure <input type="checkbox"/> Vehicle or Equipment Accident <input type="checkbox"/> Other	<input type="checkbox"/> Hard Hat <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Goggles <input type="checkbox"/> Face shield or welder helmet <input type="checkbox"/> Gloves <input type="checkbox"/> Fire Shirt <input type="checkbox"/> Fire Pants <input type="checkbox"/> Safety Shoes <input type="checkbox"/> Fireline Boots <input type="checkbox"/> Ear Protection <input type="checkbox"/> Respirator <input type="checkbox"/> Lanyards & Lifelines <input type="checkbox"/> Fluorescent Vests <input type="checkbox"/> Buoyant Work Vest <input type="checkbox"/> Warning & Control <input type="checkbox"/> Seat Belts <input type="checkbox"/> Shoulder Harness <input type="checkbox"/> Safety Equipment, National Electrical Code (NEC) <input type="checkbox"/> Lab Coat <input type="checkbox"/> Other

When submitting this report, include pictures of incident location, equipment in use, the vehicle used (if applicable), and any third party reports (i.e. Police Report, OSHA Report, etc.).

