

<b>FOR AGENCY USE ONLY</b>
Claim Number:

## SUPERVISOR'S INCIDENT ANALYSIS AND PREVENTION REPORT

**INSTRUCTIONS:**

1. Within 24 hours of notice of the incident, complete this report based on your discussion with the employee.
2. Send report to your Divisional Human Resources Representative.

**\* Indicates required information**

Employee Name	Date of Incident	Time of Incident	Date First Reported
Department Name and Location	Job Title	<b>*Employee's Usual Work Schedule at Time of Incident:</b>	
		Start time: <input type="checkbox"/> AM <input type="checkbox"/> PM	End time: <input type="checkbox"/> AM <input type="checkbox"/> PM
		Hours per week:	Days Per week:

**INCIDENT DESCRIPTION:**

Describe the incident based on your investigation. Please include:

1. **\*How did the injury/incident occur? Why?**
  
2. **\*Where did it occur?**
3. Who was involved?
4. Who did you interview?
5. If equipment was involved, was it defective?  Yes  No If YES, please explain.
6. Describe any objects being handled at the time of incident, including size and weight.

Do you agree with the employee's account of the incident?  Yes  No If NO, Please explain.

**Were safety procedures followed?**  Yes  No      **Was this activity part of their normal work duties?**  Yes  No

What corrective action should be taken to prevent a similar injury/incident?

Has the employee ever reported any physical condition(s) related to work or non-work activities (e.g. second job, participation in sports, home projects, etc.) that could be contributing to or aggravated by this injury / illness?  Yes  No If YES, please explain.

Additional Comments:

Supervisor's Name	Date
Title	Phone # (      )