

SUPERVISOR'S INVESTIGATION & REPORT OF INCIDENT

NAME OF INJURED (Last Name, First Name)	S.S.#:	D.O.B.:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ADDRESS:	CITY/ZIP CODE	HOME PHONE #:	
DEPT.:	JOB TITLE:	WORK LOCATION:	
WHEN	Date and Time of Incident: / / <input type="checkbox"/> AM <input type="checkbox"/> PM		
	Date reported to supervisor: / / If delayed, Why?		
DESCRIPTION OF INCIDENT	Detail what employee was doing (i.e. - at risk behavior) and/or what physical objects (machines, equipment), materials (chemical vapor, inhalant) (i.e. - unsafe conditions) were involved:		
	Was employee doing something other than required duties: <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, explain:		
WHAT	State body parts injured:		
	Was treatment beyond first aid required? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, explain:		
	Fatality: <input type="checkbox"/> YES <input type="checkbox"/> NO When: _____ Lost Time <input type="checkbox"/> YES <input type="checkbox"/> NO		
WHERE	Exact location where incident occurred:		
	Was ambulance transport necessary? <input type="checkbox"/> YES <input type="checkbox"/> NO To what facility?		
WITNESSES	(Last Name, First Name / Title/TEL. #):		
WHY	Comment on the causes of this incident:		
PREVENTION	What should be done and by whom to prevent recurrence of this type of incident?		
	What action are you taking to see that this is done?		
	SUPERVISOR/MANAGER'S Signature/Dept.		
	Phone # _____ Date of this report: _____		
	Employee Signature _____ Date _____ / _____ / _____ Comments:		

SUPERVISOR - DO NOT WRITE BELOW THIS LINE

Date Report Received by Safety Manager _____
 Date forwarded to HR _____
 C-2 Completed _____
 Lovell Notified _____
 Lovell Safety Management Co., LLC; 125 Maiden Lane, NYC 10038

of Days Lost: _____
 OSHA LOG # _____
 OSHA notified? (fatality, 3 hospitalizations): _____

CHECK HERE IF CONTINUED ON ADDITIONAL PAGES

YOUR COMPANY NAME