

## Supervisor and Safety Coordinator Investigation WC Claim Number Report for Injury or Illness

Employee Name (as it appears on payroll)	Employee Job Title:	Social Security Number	The occurrence was an: <input type="checkbox"/> Injury <input type="checkbox"/> Illness
<b>Supervisor's Instructions</b> (Direct any questions to your Facility Safety Coordinator or Agency's Safety Manager) 1. Sign and date the report and immediately submit within 24 hours to your Agency's Worker's Compensation Coordinator. 2. Forward a copy of the report to your Agency or Facility Safety Coordinator.			
What sources of information were used to analyze this injury/illness? <b>Check all that apply.</b> <input type="checkbox"/> Interviewed affected employee(s) <input type="checkbox"/> Interviewed witnesses <input type="checkbox"/> Examined scene <input type="checkbox"/> Reviewed records <input type="checkbox"/> Analyzed evidence <input type="checkbox"/> Other (explain)			Date paperwork received from employee (mm/dd/yyyy)
Please describe what the employee was doing when the injury/illness occurred.			
Do you agree with the employee's account of the injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.			
What corrective action has been taken? What corrective action is planned for the future? When do you plan to complete the corrective action?			
In your opinion, what can be done to prevent a similar occurrence?			
For <b>Repetitive task injuries</b> : What specific activities does the employee perform with his/her wrists, hands, arms, knees, shoulders, and/or neck? How often is the task performed? (e.g. 10 times/hour)      How many hours per day?      How many days a week?			
If <b>Material handling</b> was involved, describe the object/person being handled/lifted at time of the injury/illness. Approximate size:      Approximate weight: Description:			
If <b>Operating equipment, machinery and/or other motorized equipment/s</b> lead to injury or illness, describe the equipment/s:  Was this equipment being properly used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know If no, please explain:  Was there any other equipment/resource available to the employee but not used?			
Explain, the <b>environmental factors</b> (lighting, temperature, noise, vibration, dust, or weather), if any, that contributed to this injury or illness?			
Supervisor's Name (please print):		Title:	Date:
<b>Report prepared by (Supervisor's name):</b>			Phone Number: (    )
<b>Safety Coordinator's Instructions</b> 1. Complete this section of the report.      2. Sign and date the completed report and send to Agency WC Coordinator within 48 hours			
Is there follow up to ensure corrective actions are completed? <input type="checkbox"/> Yes <input type="checkbox"/> No, Who is responsible for follow up?			
Have corrective actions been implemented? <input type="checkbox"/> Yes <input type="checkbox"/> No, How much time is needed to implement them?			
Corrective action will be communicated to: <input type="checkbox"/> Management <input type="checkbox"/> Supervisors <input type="checkbox"/> Affected employee(s) <input type="checkbox"/> Other agency employees			
Would corrective action apply to other areas of the operation or agency? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain:			
<b>Safety Coordinator's Name:</b>		Date:	Phone Number (    )

The social security number must be provided for the use of positive identification in the processing of any claims.