APPENDIX E

(Insert City Name)

Supervisor/Employee Incident/Injury Investigation Form

Supervisor & Employee Complete The Following:

Date of Accident: _____ Time of Accident: _____ A.M. / P.M.

Address/Location of Incident:
_____

Employee Involved in Injury/Incident:
_____

Department: _____Employee Position: _____ Time in Position: ____ Yrs. ____ Mo.

Employee Complete The Following:

Describe How Injury/Incident Occurred (What you were doing):
_____

_____

_____

_____

List Cause of Injury/Incident:
_____

_____

Do You Feel You Did Everything Within Reason To Prevent This Injury/Incident? Yes / No
Explain:
_____

_____

_____

What Can be Done to Prevent Similar Future Occurrences?
_____

_____

Injury/Incident First Reported To: _____,_____
Date:_____
Name Position

If Injury/Incident was not immediately report to a supervisor, give reason why:
_____

_____

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Was PPE (Personal Protective Equipment) being used at the time of Injury/Incident? If Yes, please list type:

_____
_____

Describe Injury Type (strain, fracture, bruise, etc.) : _____ Body Part Affected:_____

Have you ever Injured this part of your body before? Yes / No If Yes, Explain: _____

_____
_____

Did anyone witness this injury/incident: Yes/No If Yes, list names of witnesses:

_____ _____
_____

Employee Signature:_____
Date:_____

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Workers' Compensation

Supervisor Complete The Following:

Supervisor's Account of Accident:
_____

_____

_____

_____

Do you feel the employee did everything within reason to prevent the accident? Yes / No
Explain Answer:
_____

_____

_____

_____

What immediate action was taken to prevent other occurrences?
_____

_____

_____ _____

Supervisor's Name (Print) **Supervisor's Signature** **Date**

Department Head Comments:

_____

_____

_____

_____

_____ _____

Department Head Name (Print) **Department Head Signature** **Date**

Witness' Statement (City Employee Only)

Describe in detail what you saw:
_____

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_____

_____

What was your location in relation to the accident (ex: 5-6' away, etc.)?: _____

What was the apparent cause of the accident?: _____

_____

_____ _____

Witness Name (Print) **Witness Signature** **Date**

(Form to be Returned to the Personnel Department within 48-hours of Incident/Injury)