

**Supervisor and  
Safety Coordinator Investigation  
Report for Injury or Illness**

WC Claim Number

|                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                    |                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--------------------------------------------------------------------------------------------|
| Employee Name (as it appears on payroll)                                                                                                                                                                                                                                                                                                                                                  |  | Employee Job Title:                                | The occurrence was an:<br><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)<br>1. Sign and date the report and immediately submit within 24 hours to your Agency's Worker's Compensation Coordinator.<br>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><br><input type="checkbox"/> Interviewed affected employee(s) <input type="checkbox"/> Interviewed witnesses <input type="checkbox"/> Examined scene<br><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?<br>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.<br>Approximate size: Approximate weight:<br>Description:                                                                                                                                                                                                         |  |                                                    |                                                                                            |
| If <b>Operating equipment, machinery and/or other motorized equipment/s</b> lead to injury or illness, describe the equipment/s:<br><br>Was this equipment being properly used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know If no, please explain:<br><br>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:                                                                                      |
| Report prepared by (Supervisor's name):                                                                                                                                                                                                                                                                                                                                                   |  |                                                    | Phone Number:                                                                              |
| <b>Safety Coordinator's Instructions</b><br>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<br>Please explain:                                                                                                                                                                                                                                      |  |                                                    |                                                                                            |
| Safety Coordinator's Name:                                                                                                                                                                                                                                                                                                                                                                |  | Date:                                              | Phone Number:                                                                              |

# Guidelines for Completing DOA-6437 Supervisor and Safety Coordinator Investigation Report for Injury or Illness

## Supervisors Instructions for filling out this report

1. Supervisors complete their section on this report and send it to the Agency's Worker's Compensation (WC) Coordinator immediately. The Worker's Compensation Coordinator will then forward the form to the Facility's Safety Coordinator or Agency Safety Manager, within 24 hours of injury/illness
2. Please note that all sections in this report must be completed. If any part of the section or question is not applicable to the job or the injury, write 'N/A' (Not Applicable) as a response. Incomplete forms might cause delays in processing of worker's compensation claims.
3. Do not forget to sign and date the completed document. A WC Coordinator might call you if there is need for more information on the claim.

## Section Instructions

The following information explains the details required in some of the sections in the report and/or its importance in processing WC claims.

What sources of information were used to analyze this injury/illness? This question provides a guideline for supervisors about what sources of information to look towards when conducting accident investigations and will help the safety coordinator determine the depth of the analysis that was conducted.

Please describe what the employee was doing while the injury/illness occurred?: This refers to the task that was being performed by the employee at the time of injury/illness and events that led to the injury/illness. Your answer should be based either on what you had witnessed personally or on other sources of information you used while analyzing the injury/illness.

Do you agree with the employee's account of the injury/illness? If there are reasons for you to believe that the cause of injury/illness was other than the one presented by the employee, please mention it here. Your opinion is important in identification of non-work related factors (not presented by the employee) that might have been the primary cause of injury/illness. For example, employee has other out-of-work hobbies such as gardening, which can be the primary reason for his or her cumulative trauma injury. **Please note that the information provided by you is kept confidential.**

What corrective action has been taken? What corrective action is planned for the future? When do you plan to complete the corrective action? The information provided in response to this question is extremely important because it gives an idea of what steps have been taken or planned to prevent similar injuries/illnesses in future.

In your opinion, what can be done to prevent similar injuries/illnesses in future?: This question asks for your opinion and suggestions as to what should be done by management, employees, safety coordinator or others to help improve safety at your workplace.

For Repetitive Task Injuries: What specific activities does the employee perform with his/her wrists, hands, arms, knees, shoulders, and/or neck? This refers to the repetitive motion activities the employee is engaged in that contributed to the injury/illness. If space permits, also mention activities usually performed by the affected employee. Examples include lifting, tightening screws and typing.

How often is the task performed? This question refers to the frequency with which the repetitive task is performed and the length of time it is performed for (10 times per hour).

If Material Handling was involved, describe the object/person being handled/lifted at the time of injury/illness.: Specify the details of object/person being handled that caused the injury/illness, including weight and size. Approximations for weight and size can be used, if necessary.

If Operating equipment, describe the equipment that was in use at the time of injury/illness? Specify the material handling equipment that caused the injury/illness. For example, forklift truck.

Explain the environmental factors, if any: This question refers to the contributing environmental factors that lead to the injury/illness.

If you have any questions regarding this report, please contact your Agency's Worker's Compensation Coordinator or Safety Coordinator.

### **Safety Coordinators Instructions for completing this report**

1. The Facility's Safety Coordinator or Agency's Safety Manager should fill out their section on this report after the analysis of the injury. It is important that the safety coordinator should evaluate the information gathered through other sources.
2. Send completed copy of the report to the Agency's Worker's Compensation Coordinator within 48 hours of receipt.

### **Section Instructions**

The following information explains the details required in some of the sections in the report and/or its importance in processing WC claims.

*Is there follow-up to ensure corrective actions are completed:* Please follow-up with the supervisor to ensure that proper corrective action was taken. Also mention the name or title of the person responsible for the follow-up.

*Have corrective actions been implemented:* The answer to this statement helps determine whether corrective actions that were completed to ensure similar injuries don't happen in future have been incorporated as part of the safety program.

*Corrective action will be communicated to:* This question helps understand the people who will be informed of the corrective actions that should be taken in order to prevent any similar injuries in the future.

*Would corrective action apply to other areas of the operation or agency?:* If there are other areas or operations in the agency where the corrective actions can be applied, please mention it. It is important to determine extent of the scope of correction in order to be more proactive and prevent future injuries and illness.