



# SUPERVISOR'S INCIDENT REPORT AND ANALYSIS

<b><u>PART OF BODY AFFECTED</u></b>			<b><u>NATURE OF ILLNESS / INJURY / EXPOSURE</u></b>		
<b><u>Head/Neck</u></b>	<b>LEFT SIDE</b>	<b>RIGHT SIDE</b>	<input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Cut/Abrasion <input type="checkbox"/> Foreign Body <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Skin Rash <input type="checkbox"/> Jammed Appendage <input type="checkbox"/> Fracture/Dislocation <input type="checkbox"/> Amputation <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Seizure <input type="checkbox"/> Electric Shock <input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Bloodborne Exposure <input type="checkbox"/> Exposure–Body Fluid <input type="checkbox"/> Exposure–Airborne <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Occupational Illness <input type="checkbox"/> Mental Health <input type="checkbox"/> Other: _____		
<b><u>Upper Extremities</u></b>			<b><u>WORK ACTIVITY AT TIME OF INCIDENT</u></b>		
<input type="checkbox"/> Shoulder <input type="checkbox"/> <input type="checkbox"/> Upper Arm <input type="checkbox"/> <input type="checkbox"/> Elbow <input type="checkbox"/> <input type="checkbox"/> Forearm <input type="checkbox"/> <input type="checkbox"/> Wrist <input type="checkbox"/> <input type="checkbox"/> Hand <input type="checkbox"/> <input type="checkbox"/> Fingers <input type="checkbox"/>			<input type="checkbox"/> Regular Work Duties <input type="checkbox"/> Training <input type="checkbox"/> Police Duties <input type="checkbox"/> Firefighting <input type="checkbox"/> Medical Call <input type="checkbox"/> HazMat Emergency <input type="checkbox"/> Other: _____		
<b><u>Lower Extremities</u></b>			<b><u>TYPE OF INCIDENT</u></b>		
<input type="checkbox"/> Thigh <input type="checkbox"/> <input type="checkbox"/> Lower Leg <input type="checkbox"/> <input type="checkbox"/> Knee <input type="checkbox"/> <input type="checkbox"/> Ankle <input type="checkbox"/> <input type="checkbox"/> Foot/Toes <input type="checkbox"/>			<input type="checkbox"/> Vehicle Collision <input type="checkbox"/> Fall <input type="checkbox"/> Puncture <input type="checkbox"/> Exposure to Poison Oak <input type="checkbox"/> Insect Bite/Sting <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Lifting / Carrying <input type="checkbox"/> Struck By/Against <input type="checkbox"/> Caught In/Under <input type="checkbox"/> Overexertion <input type="checkbox"/> Body Reaction <input type="checkbox"/> Chemical Exposure <input type="checkbox"/> Temperature Extreme <input type="checkbox"/> Potentially Infectious Contact <input type="checkbox"/> Other: _____		
<b><u>Trunk</u></b>			<b><u>CONTRIBUTING FACTORS</u></b>		
<input type="checkbox"/> Upper Back <input type="checkbox"/> <input type="checkbox"/> Lower Back <input type="checkbox"/> <input type="checkbox"/> Chest <input type="checkbox"/> <input type="checkbox"/> Abdomen <input type="checkbox"/> <input type="checkbox"/> Hip <input type="checkbox"/> <input type="checkbox"/> Groin <input type="checkbox"/>			<input type="checkbox"/> Defective Tools/Equipment <input type="checkbox"/> Poor Housekeeping <input type="checkbox"/> Tool/Equipment Broke <input type="checkbox"/> Faulty Floor/Surface <input type="checkbox"/> None <input type="checkbox"/> Weather: _____ <input type="checkbox"/> Other: _____		
<b><u>Other</u></b>			<b><u>SAFETY EQUIPMENT IN USE</u></b>		
<input type="checkbox"/> Digestive System <input type="checkbox"/> Respiratory System <input type="checkbox"/> Skin <input type="checkbox"/> Other: _____			<input type="checkbox"/> Latex Gloves <input type="checkbox"/> Safety Boots/Shoes <input type="checkbox"/> Safety Chaps <input type="checkbox"/> Leather Work Gloves <input type="checkbox"/> Safety Glasses/Goggles <input type="checkbox"/> Hearing Protection <input type="checkbox"/> Other Work Gloves <input type="checkbox"/> Face Shield <input type="checkbox"/> Back Belt <input type="checkbox"/> Seat Belt <input type="checkbox"/> Hard Hat <input type="checkbox"/> Retroreflective Clothing <input type="checkbox"/> EMS Glasses/Goggles <input type="checkbox"/> EMS Gown <input type="checkbox"/> EMS Respirator <input type="checkbox"/> SCBA <input type="checkbox"/> SCBA Hood <input type="checkbox"/> Fire Gloves <input type="checkbox"/> Fire Structural Coat <input type="checkbox"/> Fire Wildland Shirt <input type="checkbox"/> Fire Boots/Shoes <input type="checkbox"/> Fire Structural Pants <input type="checkbox"/> Fire Wildland Pants <input type="checkbox"/> Fire Face Shield <input type="checkbox"/> Fire Structural Helmet <input type="checkbox"/> Fire Wildland Helmet <input type="checkbox"/> Other: _____		

<b>TREATMENT</b>	<b>WORK STATUS FOLLOWING INCIDENT</b>
<input type="checkbox"/> Reporting Only <input type="checkbox"/> First-Aid Only <input type="checkbox"/> Sought Medical Treatment <input type="checkbox"/> Hospitalized	<p style="text-align: center;"><b>CHECK ALL THAT APPLY</b></p> <input type="checkbox"/> <b>Did NOT finish shift on date of injury</b> <input type="checkbox"/> Not Returned to Work <input type="checkbox"/> Returned to Modified Duty      Date Returned: _____ <input type="checkbox"/> Returned to Full Duty              Date Returned: _____

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Is the Hazard sufficiently controlled to prevent further injury?  Yes  No  N/A

Was first-aid provided to ensure well-being of injured employee?  Yes  No  N/A

Is the scene secured to protect clues for analysis purposes?  Yes  No  N/A

## Incident Debriefing Questions

1. What was the main objective for the work activity happening at the time of the incident?

2. What equipment/vehicle was involved?

3. Please list all employees on assignment for this job/activity.

4. Please list all non-employees involved, along with their contact information, if applicable.

5. What happened, what malfunctioned, and/or what went wrong that led to the incident?

6. Was equipment being used in a manner other than what it was intended or designed for?  Yes  No  
If yes, please explain.

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7. Was Personal Protective Equipment (PPE) / Safety Equipment in Use a factor in the incident?  Yes  No
- a. If yes to question 7, was PPE being used and in good working condition?  Yes  No  N/A
- b. If yes to question 7, was PPE adequate for the job being done?  Yes  No  N/A
- If no for either a or b above, please explain.

8. Might there be another way to perform the task that would help prevent a similar occurrence?  Yes  No
- If yes, please explain.

9. Could additional training help prevent a similar occurrence?  Yes  No
- If yes, please explain.

10. Were all applicable policies and procedures being followed at the time of incident?  Yes  No
- If no, please explain.  Unknown

Might a procedure need to be changed or added in light of the incident?  Yes  No

If yes, please explain.

Is there an engineering solution / a way to engineer a fix to the problem?  Yes  No

If yes, please explain.

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Please describe how the issues listed in this report will be addressed, AND, when applicable, please describe what actions have been or will be taken to correct these issues with completion date.	Person Assigned:	Completion Date:

Employee:	_____	_____	_____
	Printed Name	Signature	Date
Supervisor:	_____	_____	_____
	Printed Name	Signature	Date
Department Head:	_____	_____	_____
	Printed Name	Signature	Date

**Risk Management & Safety Committee Notes:**

**Department Safety Committee**  
 Review Date: \_\_\_\_\_ Signature Department Committee Chair: \_\_\_\_\_  
 Observations/Questions/Follow-up: \_\_\_\_\_

**City-Wide Safety Committee**  
 Review Date: \_\_\_\_\_ Signature City-Wide Committee Chair: \_\_\_\_\_  
 Observations/Questions/Follow-up: \_\_\_\_\_

Follow-up Completed Date: \_\_\_\_\_

Signature of Risk Manager: \_\_\_\_\_

**All originals to Risk Management within 2 business days.**