Key Risk
a Berkley Company

Supervisor Accident Investigation Report

Report Completed by: (Supervisor):			***Date:***
Name of Injured Employee	Job Title	Employee Classification ☐ FT ☐ PT ☐ Temp	Branch/Jobsite Location of Injury
Injured Employee's Department	Date & Time Injury Occurred	Supervisor	Date & Time Reported to Supervisor
Task Performed when Injured	Exact Location of Injury Occurrence	Was Task (Check One): ☐ Routine ☐ Infrequent ☐ New	How long Employed?

When Did Injury Occur in Shift (Check One) ☐ Early ☐ Near Break ☐ Late ☐ OT	Occurred on Company Premises? ☐ Yes ☐ No	Injured Employee Experience in Job Task (Check One) ☐ New ☐ Novice ☐ Competent ☐ Expert ☐ Unauthorized

Date On-Scene Observation of Accident Site made by Supervisor?	Photos/Sketches Taken? ☐ Yes ☐ No	Any Witnesses? ☐ Yes ☐ No If Yes, attach Statements	Accident Evidence Secured? ☐ Yes ☐ No

Was Post-Accident Drug Testing Administered: ☐ Yes ☐ No If Yes, Where?	Physician/Hospital Authorized by Employer? ☐ Yes ☐ No Name
Has the injured employee and medical provider been informed that **transitional duty work** will be offered for immediate return to work within medical restrictions? Yes ☐ No ☐	Additional Comments:

Nature of Injury and Body Parts Affected: (e.g., cut left thumb, broke right arm, strained lower back, etc.)

Severity of Injury/Illness.	***Work Status Following Initial Medical Treatment (Anticipated)***
☐ "Near-Miss" Accident (no injury) ☐ First-Aid (in house treatment only) ☐ Minor Medical (initial doctor treatment, then release) ☐ Serious (partial disability, continuing medical care) ☐ Catastrophic (hospitalization, critical condition, severe disability, fatality)	☐ Full Duty Return to work on next shift ☐ Transitional Duty Return to work on next shift ☐ Lost Time (did not return to work on next shift)

Cause of Injury/Illness.

☐ Slip/Trip/Fall onto same level	☐ Struck-Against (hit on, bumped into)	☐ Contact With (Electrical, Chemical, Heat/Cold)
☐ Fall from above level (ledge, platform, ladder, stairs)	☐ Struck By (hit by something/someone)	☐ Foreign Material in Eye
☐ Caught In/On/Between (pinched, snagged, grabbed)	☐ Repetitive Motion Condition	☐ Bio-hazard Exposure (needle stick, blood)
☐ Overexertion (strain from force, exhaustion) Vehicle Accident	☐ Animal/Insect Bite Respiratory Exposure	☐ Cut by sharp object (knife, blade)
☐ Other	☐	☐

Describe in Detail How the Accident Occurred.

Comment on equipment/tools, materials, people, vehicles, or environmental factors (such as noise, lighting, heat, cold, etc.) that may have contributed.

Protective Gear Used by Injured Employee (when incident occurred).

Specify any PPE worn at time of incident (e.g., hard hat, face shield, fall protection harness, respirator, gloves, etc.).

Immediate Causes of Accident (identify both behavior(s) and conditions(s). Check as many as applicable.

Behaviors/Work Practices

- ☐ Using Improper Equipment (wrong type/damaged)
- ☐ Abuse or Misuse of Equipment
- ☐ Removing Safety Devices or Making them Inoperable
- ☐ Failing to Use PPE or Seatbelts
- ☐ Improper Placement or Storage of Materials (unstable)
- ☐ Improper Handling Technique (help, grip, reach, posture)
- ☐ Failure to Use Safe Lift Handling Equipment (carts, lifts, etc.)
- ☐ Patient Handling/Improper Body Position or Overreaching
- ☐ Working on Equipment in Motion
- ☐ Performing Work at Unsafe Speed or Pace
- ☐ Not Authorized or Qualified to Perform Task
- ☐ Failure to Isolate/Secure/Lockout Energized Equipment
- ☐ Horseplay

☐ Inadequate Ventilation ☐ Temperature Extremes ☐ Drug/Alcohol Abuse

Physical Conditions

- ☐ Inadequate Guards/Barriers/Safety Devices
- ☐ Inadequate or Improper Protective Equipment
- ☐ Defective/Worn Tools or Equipment in Service
- ☐ Congested/Restricted Area/No Separation
- ☐ Fire or Explosion Hazard
- ☐ Working Surface Unsafe (slippery, sloped)
- ☐ Poor Housekeeping/Disorder
- ☐ Noise/Vibration
- ☐ Hazardous Materials/Chemicals Used
- ☐ Visibility Inadequate (dark, glare, obscured)
- ☐ Heavy Work Uncontrolled
- ☐ Production Pace Unsafe
- ☐ Emergency Systems/Provisions inadequate

☐ Poor Traffic Flow

Root causes of Accident (identify both personal factor(s) and management practice factor(s). Check as many as applicable.

Possible Personal Factors

- ☐ Insufficient Knowledge
- ☐ Insufficient Skill
- ☐ Insufficient Experience
- ☐ Insufficient Motivation
- ☐ Fatigue (mental or physical)
- ☐ Personal Issues
- ☐ Other:

Possible Management Practice Factors

- ☐ Leadership/Supervision/Enforcement
- ☐ Engineering/Design/Capacity/Containment
- ☐ Process/Work methods
- ☐ Maintenance/Inspection Program
- ☐ Staffing/Manpower/Hiring Practices
- ☐ Tools/Equipment Provided
- ☐ Hazardous Materials Alternatives/Controls
- ☐ Training/Development
- ☐ Hazard Identification/Evaluation

Other/Comments:

Preventative Measures to Consid er. Check as many as applicable.

- ☐ General Enforcement Improvement
- ☐ Training or Re-Training of Employees
- ☐ Individual Corrective Counseling
- ☐ PPE Improvement
- ☐ Staffing/Hiring Stds./Development
- ☐ Rotation of Employees
- ☐ Employee Awareness/Communication of Employee(s)
- ☐ Housekeeping/Disposal improvement
- ☐ Substitute Safer Alternative Material
- ☐ Guards/Safety Devices Improvement
- ☐ Engineering/Process Improvement
- ☐ Visibility/Illumination Improvement
- ☐ Storage/Arrangement Improvement
- ☐ Provide Employee Incentive
- ☐ Safety Efforts Effectiveness
- ☐ Remove/Eliminate Hazard
- ☐ Job Re-Assignment
- ☐ Remove Employee Disincentive
- ☐ Warning System Provided
- ☐ Repair/Replace Equipment
- ☐ Congestion/Traffic Improvement
- ☐ Supply/Purchasing Improvement
- ☐ Insp./Maintenance Improvement
- ☐ Noise/Vibration Improvement
- ☐ Emergency Systems/Provisions
- ☐ Conduct Hazard Analysis
- ☐ Formal Procedure Devep/Update
- ☐ Work Method Improvement
- ☐ Workstation Re-Design
- ☐ Temperature Improvement
- ☐ Ventilation Improvement
- ☐ Discontinue/Eliminate Task
- ☐ Other/Comments:

Specific Corrective Action(s) Taken	***Person(s) Responsible***	***Target Date***	***Date Completed***

Report Corrective Action(s) Updates Completed by: (Supervisor):		***Date:***	
Manager Comments:	Executive Comments:	Safety Committee Comments:	