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**General Services Department**
**Risk Management Division**
**Loss Control Bureau**

# Supervisor's Incident Investigation Report of Loss

To be completed by the supervisory person most immediately responsible for the operation in which the loss occurred as soon as possible after the occurrence. Forward report to the office/person designated by the institution. This information is for use in preventing similar losses in the future and claim assessments.

## A. Type of Loss:

Describe Loss:

Name of Injured Worker:

Job Title: Department:

Name(s) of Witness(es):

Witness Locations:

Date and Time of Loss:

Date and Time of Loss Reported:

General Location of Incident:

Specific Location of Incident:

Was injured employee performing normal job duties? ☐ **YES** ☐ **NO** ☐ **N/A**

If no, describe job when injury occurred:

**Supervisor must complete all pages before submittal.**

**Injury Information (check location and type if applicable):** ☐ Right Side ☐ Left Side ☐ N/A

| | | | | | |
|---|---|---|---|---|---|
| ☐ Head | ☐ Face | ☐ Eye | ☐ Ear | ☐ Nose | ☐ Mouth |
| ☐ Neck | ☐ Back | ☐ Chest | ☐ Abdomen | ☐ Groin | ☐ Buttocks |
| ☐ Shoulder | ☐ Arm | ☐ Elbow | ☐ Wrist | ☐ Hand | ☐ Pinky |
| ☐ Fingers | ☐ Thumb | ☐ Index | ☐ Middle | ☐ Ring | ☐ Toes |
| ☐ Leg | ☐ Thigh | ☐ Knee | ☐ Calf | ☐ Foot | |

Other:

| | | | |
|---|---|---|---|
| ☐ Laceration | ☐ Contusion | ☐ Abrasion | ☐ Sprain / Strain |
| ☐ Burn | ☐ Fracture | ☐ Amputation | ☐ Puncture |
| ☐ Dermatitis | ☐ Crushing | ☐ Electric Shock | ☐ Chemical Exposure |

**Describe activity at the time of injury (check related activities and provide description if applicable):**

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ Walking | ☐ Running | ☐ Lifting | ☐ Carrying | ☐ Climbing | ☐ Pushing | ☐ N/A |
| ☐ Kneeling | ☐ Jumping | ☐ Pulling | ☐ Bending | ☐ Bending | ☐ Reaching | |

Detailed Description:

If material handling, describe object lifted / carried:

Object's Weight: Dimensions:

**Describe object, machine, or equipment involved in the incident:**

Guards and safety devices in place?: ☐ Yes ☐ No ☐ N/A

Describe:

Chemical involved in incident: ☐ Yes ☐ No ☐ N/A

Describe:

Rush in production schedule or job duties: ☐ Yes ☐ No ☐ N/A

Describe:

**Analysis of the loss:** *( Give your opinion as to why the loss happened and how it could have been avoided)*

**Prevention:** *(What have you done or what would you recommend be done to prevent a similar loss? )*

## Person Completing Report:

Print:

Signature:

Date

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# Supervisor's Incident Investigation Report of Loss
# Employee and Witness Account of the Incident

Employee / Witness Name:

Job Title: Department:

Describe where you were when the incident occurred:

Describe what you observed just before the incident occurred; **be specific**:

Describe what you observed when the incident happened:

Describe what you observed just after the incident occurred:

Employee/Witness Signature: Date:

Supervisor Signature: Date: