E^, n E ,Z ^Z Œ ^ ŒÀ] • n t}Œ I Œ•[}u‰ v• Supervisor Accident/Injury/Incident Investigative Report

Department: Employee Name:

Department Location: JobTitle: regularjob functions? z • E }

If not, explain:

WZÇ•] o u vs WØEÇZ ÀÇÁ,} ŒÀÌÇÁ } ŒID

^ vš ŒÇÁ}Œ

E }

Was employee working overtime? z • E } If yes,explain:

E}š]}(/viµŒÇ ^-í_ (}Œu }u‱• šE}W

Injury reported to: Date reported:

Location of Accident/Incident: Time of Accident/Incident:

BodyPart/s injured: Typeof injury:

Severity of Injury/Action Taken

E} š]}všIv &]Œ•š] ŒXs]•]š hŒPvšŒZs]•]š

Doesthe employeehave restrictedduty? z • E } Did the employeedosetime from work?

Describein detail what happened:

Causesof Accident/Injury: Section 1

^ o š oošZ 𠉉oÇX

Environmental Work Conditions

Personal Factors

t š Z Œ } v] š] } v DefectiveEquipment/Tools Unsafe Act

, š W}}ŒZ}μ∙Ι‰]vPIομššŒ Lackof Knowledge/Skill

Cold InadequateWorkspace Improper Motivation

Noise Uneven/WetWalkingSurface Inadequate Planning

Smoke/Fumes InadequateProtectionEquipm v š Fatigue/Stress

Dust InadequateLighting Deviation fromProcedure

Other InadequateVentilation Violation of Safety Rule

Other Other

Causesof Accident/Injury: Section 2

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Job Factors

Management Issues

PoorWork AreaSetup/Design Insufficient Planning

Improper or Inadequat€quipment/Tools BudgetaryConstraints

Lackof Procedures/SafetRules Insufficient Training

Maintenance Issues Safety Issue Not Prioritized/Emphasized

InadequateSafetyInspections Insufficient Enforcement SafetyRules

InadequateResources Understaffed

Causesof Accident/Injury: Section 3 (Complete only for slips, trips, and fallsequired)

ŽPlease includeparotographof the specific location and anything that may have caused the slip, trip, or fall.

Was there aspecific hazarthat may have caused the injury/accident? Yes No

If yes, explain:

Didt Z ì.P

sCsu42J 60 >>aver <<0.052 Tc 33w 12TJ 60 >>day?MC /P753t

EMC /P753t

Did

Job JoTry/6.402 Td6 -23.4 Tw -6 -6Fr0>>BD (Did)Tj -0.055 Tw 176Fr1n731 0 fic ÞCSà fŒÖ0Did t Z Ú& F ì

Corrective Action Plan (Include immediate, short term, and long term plan)

Immediate Action

Assigned To:	DateCompleted:
Short Term Plan	
Assigned To:	DateCompleted:
Long Term Plan	
Assigned To:	DateCompleted:
Printed Name	
Signature:	Date:
The correctivaction plan should be directed towarpreventingfuture accidens that are similar in natureby the employee abover by other employees that share related duties.	

Please submit form to Workers Compensation Departmenta fax at (775) 784-4363 or viæ-mail at BCNRisk@unr.edu