COPIES TO: DIVISION HEAD
ORIGINAL TO: HUMAN RESOURCES

CITY OF FOND DU LAC – SUPERVISOR INCIDENT INVESTIGATION FORM

(TO BE COMPLETED BY SUPERVISOR)

Complete this form within 24 hours of receiving Employee Incident Report Form

TYPE OF INCIDENT	☐ BODILY INJURY	☐ PROPERTY DAMAGE	☐ NEAR MISS

Supervisor Name: _____ Date: _____

Name of Injured Employee: _____ Injury Date/Time: _____

Department/Division: _____ Job Title: _____

Witness (if applicable): _____

SPECIFIC LOCATION WHERE INCIDENT OCCURRED	
HOW COULD THIS BE PREVENTED?	
WAS THIS CAUSED BY AN UNSAFE ACT/CONDITION?	

Have similar incidents occurred before with this employee?	☐ YES	☐ NO	☐ UNSURE
Have similar incidents occurred before within this division?	☐ YES	☐ NO	☐ UNSURE

Employee's Verbal Statement:

Witness Statement (if available):

INJURY DESCRIPTION

☐	AMPUTATION	☐	DERMATITIS	☐	NO APPARENT INJURY
☐	BACK STRAIN	☐	EYE INJURY		OTHER: LIST
☐	BREAK/FRACTURE	☐	REPETITIVE MOTION		
☐	BRUISE/ABRASION	☐	SPRAIN/STRAIN		

INJURED BODY PART

		L	R			L	R	
☐	SKULL/SCALP	☐	☐	SHOULDER	☐ BACK, UPPER	☐	☐	THIGH
☐	FACE	☐	☐	ARM (UPPER)	☐ BACK, MIDDLE	☐	☐	KNEE
☐	EAR	☐	☐	ELBOW	☐ BACK, LOWER	☐	☐	CALF/SHIN
☐	NOSE	☐	☐	FOREARM	☐ CHEST	☐	☐	ANKLE
☐	MOUTH/TEETH	☐	☐	WRIST	☐ ABDOMEN	☐	☐	FOOT
☐	NECK	☐	☐	HAND	☐ HIPS/PELVIS	☐	☐	TOE(S)
☐	EYE(S) Left/Right	☐	☐	FINGER(S) Thumb/Digit # ___	OTHER:			

CAUSE OF THE INCIDENT

☐	HOUSEKEEPING	☐	PHYSICAL AND ENVIRONMENTAL STRESS
☐	MATERIALS/TOOLS/PROCESSES	☐	EXCEEDING LIMITS (SPEED/STRENGTH)
☐	WORK PRACTICES	☐	EXCESSIVE PHYSICAL DEMANDS
☐	HAZARDS NOT RECOGNIZED	☐	FAULTY EQUIPMENT/MACHINERY
☐	FAILURE TO PLAN/ANTICIPATE	☐	MAINTENANCE/INSPECTIONS/REPAIRS
☐	LACK OF PROCEDURES	☐	INADEQUATE CONSTRUCTION/LAYOUT
☐	RESOURCES LACKING	☐	FAILED TO USE PERS. PROTECT. EQUIP.
☐	FAILURE TO ACT/CORRECT	☐	INADEQUATE STAFF
☐	INADEQUATE TIME	☐	HORSEPLAY
☐	KNOWLEDGE/SKILLS LACKING		OTHER:

Please explain the above checked causes:

1._____

2._____

3._____

4._____

CORRECTIVE ACTION

ACTION TO PREVENT	INDIVIDUAL(S) RESPONSIBLE	COMPLETION DATE
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.

LOST TIME/MEDICAL TREATMENT

WAS MEDICAL TREATMENT SOUGHT AT TIME OF REPORT?	☐	NO	☐	YES	LOCATION:	
DO YOU FORESEE ANY MISSED WORK TIME?	☐	NO	☐	YES	EST. DAYS:	

Do you have any concerns about this incident?

If not a bodily injury incident, is follow up necessary? If so, describe follow-up plan to avoid recurrence.

SUPERVISOR SIGNATURE: _____

DATE: _____

CR# (PD): _____