

Supervisor's Accident/Incident Investigation Report –

For Injuries to Employees

Directions: This report should be completed on all injuries. This report is to be completed in *addition* to the *Workers' Compensation First Report of Injury*. Return the completed form to the *Human Resources Department* along with the First Report of Injury or within five working days of sending the First Report of Injury.

1. Injured employee's Full Name and Department:
2. Time, Date and Location of where Accident/Incident occurred:
3. Witness(s):
4. Describe details of Accident/Incident resulting in injury, including events prior to and following the injury:
5. What were factors contributing to the accident?
6. Was Personnel Protective Equipment (PPE) required? **Yes** **No**
If Yes, was the PPE properly utilized? **Yes** **No**
If No, please explain:
7. Is the location of the Accident/Incident where the employee should be during their employment with Cobb County? **Yes** **No**

If No, please explain why the employee was in this area:
8. How could we have prevented this Accident/Incident?
9. Explain similar accidents that have occurred within two years.
10. What Acts, Failures to Act, and/or Conditions contributed most directly to this Accident/Incident?
11. What corrective actions have been taken to prevent this accident from reoccurring? If none, explain why.
12. Describe the type of injury including complaints and/or visible signs of injury.
13. Has the employee injured this body part before? **Yes** **No**
14. Has the employee ever filed a Workers' Compensation Claim before? **Yes** **No**

Supervisor's Name Completing Report

Signature

Date

Department Manager Signature

Date