



SUPERVISOR'S INVESTIGATION REPORT CITY OF STOCKTON

For Instructions See
INSTRUCTIONS FOR
FORM COMPLETION

Injured Employee: _____ DOB _____ SS# _____ Male
Female

Home Address: _____ () _____
Street City Phone Number Date of Hire

Date Injured _____ Time ____:____ AM PM Dept. _____ Job Class _____
Time employee started work Time ____:____ AM PM (Indicate Main Department, e.g., Police, CDD)

Date Injury Reported _____ Time Injury Reported ____:____ AM PM

Nature/Extent of injury: _____

Engaged in what work when injured? _____

Was medical treatment offered? YES NO Was employee seen by a hospital/doctor? YES NO

Was employee treated in an Emergency Room? YES NO Was employee hospitalized overnight as an in-patient? YES NO

Name/Address of Doctor or hospital where employee was treated: _____

Name of Doctor/Hospital Street City Number of lost workdays

A						
NATURE OF INJURY	PART OF BODY	ACCIDENT TYPE	UNSAFE CONDITION	UNSAFE ACT	CONTRIBUTING CAUSE (Indirect)	
101 <input type="checkbox"/> Cut/puncture	201 <input type="checkbox"/> Head	301 <input type="checkbox"/> Slip/fall same level	401 <input type="checkbox"/> Inadequate or no safety guards	501 <input type="checkbox"/> Operating without auth.	601 <input type="checkbox"/> Minimum training	
102 <input type="checkbox"/> Strain/Sprain	202 <input type="checkbox"/> Face	302 <input type="checkbox"/> Slip/fall different level	402 <input type="checkbox"/> Poor Housekeeping	502 <input type="checkbox"/> Using defective equip.	602 <input type="checkbox"/> Fatigue	
103 <input type="checkbox"/> Contusion (bruise)	203 <input type="checkbox"/> Eye <input type="checkbox"/> Left <input type="checkbox"/> Right	303 <input type="checkbox"/> Struck against	403 <input type="checkbox"/> Unsafe/defective equipment	503 <input type="checkbox"/> Failure to use safety device or protective equipment	603 <input type="checkbox"/> Pre-existing physical weakness	
104 <input type="checkbox"/> Burn (heat or chemical)	204 <input type="checkbox"/> Neck	304 <input type="checkbox"/> Struck by	404 <input type="checkbox"/> Inadequate illumination or noise control	504 <input type="checkbox"/> Failure to make secure	604 <input type="checkbox"/> Intoxicated	
105 <input type="checkbox"/> Fracture	205 <input type="checkbox"/> Shoulder <input type="checkbox"/> Left <input type="checkbox"/> Right	305 <input type="checkbox"/> Caught in between	405 <input type="checkbox"/> Hazardous personal attire	505 <input type="checkbox"/> Improper use of equipment	605 <input type="checkbox"/> Inattentive	
106 <input type="checkbox"/> Crush Injury	206 <input type="checkbox"/> Arm <input type="checkbox"/> Left <input type="checkbox"/> Right	306 <input type="checkbox"/> Strain/overexertion	406 <input type="checkbox"/> Improper ventilation	506 <input type="checkbox"/> Safety rule was violated	606 <input type="checkbox"/> Nervous, excitable, impatient	
107 <input type="checkbox"/> Dislocation	207 <input type="checkbox"/> Elbow <input type="checkbox"/> Left <input type="checkbox"/> Right	307 <input type="checkbox"/> Inhale, Absorb, Ingest	407 <input type="checkbox"/> Hazardous established procedure	507 <input type="checkbox"/> Unsafe loading, placing, carrying, lifting	607 <input type="checkbox"/> Lost temper	
108 <input type="checkbox"/> Skin Irritation	208 <input type="checkbox"/> Hand <input type="checkbox"/> Left <input type="checkbox"/> Right	308 <input type="checkbox"/> Electrical	408 <input type="checkbox"/> Slippery Surface	508 <input type="checkbox"/> Took unsafe position/posture	608 <input type="checkbox"/> Willful disregard of instructions	
109 <input type="checkbox"/> Infection	209 <input type="checkbox"/> Finger	309 <input type="checkbox"/> Temperature extreme	409 <input type="checkbox"/> Congestion, close clearance	509 <input type="checkbox"/> Operating at unsafe speed	609 <input type="checkbox"/> Other person	
110 <input type="checkbox"/> Effects of environment	210 <input type="checkbox"/> Back & spine	310 <input type="checkbox"/> Attack/assault	410 <input type="checkbox"/> No unsafe condition	510 <input type="checkbox"/> Unsafe procedure	610 <input type="checkbox"/> No significant personal factor	
111 <input type="checkbox"/> Foreign object	211 <input type="checkbox"/> Trunk (including hips)	311 <input type="checkbox"/> Bite or sting	411 <input type="checkbox"/>	511 <input type="checkbox"/> Horseplay		
112 <input type="checkbox"/> Splash	212 <input type="checkbox"/> Leg <input type="checkbox"/> Left <input type="checkbox"/> Right	312 <input type="checkbox"/> Horseplay		512 <input type="checkbox"/> No unsafe act		
113 <input type="checkbox"/> Other	213 <input type="checkbox"/> Knee <input type="checkbox"/> Left <input type="checkbox"/> Right	313 <input type="checkbox"/> Vehicular		512 <input type="checkbox"/>		
	214 <input type="checkbox"/> Ankle <input type="checkbox"/> Left <input type="checkbox"/> Right	314 <input type="checkbox"/> Cut/Puncture				
	215 <input type="checkbox"/> Foot <input type="checkbox"/> Left <input type="checkbox"/> Right	315 <input type="checkbox"/>				
	216 <input type="checkbox"/>					

B. WHAT HAPPENED AND WHERE DID IT HAPPEN? Include missing details uncovered by your investigation. Furnish the following: WHAT happened and the physical location WHERE it happened

If more space needed --press the TAB key, and answer YES either before or when no more typing is permitted (400 characters)

Witnesses: _____

C. CAUSE OF ACCIDENT What acts, failures to act and/or conditions contributed most directly to accident – the WHY & HOW

If more space needed --press the TAB key, and answer YES either before or when no more typing is permitted (400 characters)

D. CORRECTIVE ACTION What action has been taken, will be taken, or is recommended, to prevent recurrence? (Mark "X" by those items completed.)

If more space needed --press the TAB key, and answer YES either before or when no more typing is permitted (400 characters)

Supervisor's Name (Print): _____ **Date form completed:** _____

Supervisor's Signature: _____ **Telephone #** _____

E. DEPARTMENT HEAD'S CONCURRENCE/COMMENTS Review for concurrence or return for additional action.

Department Head's Name (Print): _____ **Date** _____

Department Head's Signature: _____



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To be used if additional space is necessary for items B, C or D on first page

B. WHAT HAPPENED AND WHERE DID IT HAPPEN (continued from page 1)

When completed, press the TAB key to move back to item C on first page

C. CAUSE OF ACCIDENT (continued from page 1)

When completed, press the TAB key to move back to item D on first page

D. CORRECTIVE ACTION (continued from page 1)

When completed, press the TAB key to move back to "Date Form Completed" on first page

E. DEPARTMENT HEAD'S CONCURRENCE/COMMENTS(continued from page 1).

When completed, press the TAB key to move back to "Date Form Completed" on first page

IMPORTANT! – PLEASE DISTRIBUTE TO:

Original - City Safety Officer **One Copy** - Department File

One Copy - Department Safety Coordinator