



**Washington Hospitals
Workers' Compensation Program**
P.O. Box 19557, Seattle, Washington 98109
206-285-3955 Fax: 206-283-6122

OSHA Log Case
or Claim Number
(if applicable)

SUPERVISOR'S INVESTIGATION REPORT

Supervisor: Complete the Supervisor's Investigation Report within 24 hours, retain a file copy. Give original to route to facility designated contact (DC).

*Make and distribute internal copies as needed. **FAX, then MAIL fully completed original to Workers' Compensation Program.***

SEVERITY OF INCIDENT: This is a report of (<i>check one</i>)		<input type="checkbox"/> DEATH		<input type="checkbox"/> LOST TIME		<input type="checkbox"/> MEDICAL TREATMENT		<input type="checkbox"/> FIRST AID ONLY		<input type="checkbox"/> NEAR MISS		
HOSPITAL				INJURED EMPLOYEE NAME				TITLE/DEPARTMENT		SHIFT HOURS		
DATE OF INJURY		TIME		DATE REPORTED TO YOU		DATE OF HIRE		SEVERITY POTENTIAL <input type="checkbox"/> MAJOR <input type="checkbox"/> SERIOUS <input type="checkbox"/> MINOR				
		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.						PROBABLE RECURRENCE <input type="checkbox"/> FREQUENT <input type="checkbox"/> OCCASIONAL <input type="checkbox"/> RARE				
NAME OF WITNESS(ES)												
Accident/Cause	WHAT HAPPENED & WHY DID IT HAPPEN?								Describe what took place or what caused you to make this investigation. Get all the facts by studying the job and situation involved. Question by use of WHY - WHAT - WHERE - WHEN - WHO - HOW			

IF SERIOUS INJURY OR FATALITY, HAS AREA BEEN SECURED, EVIDENCE PRESERVED, AND DEPARTMENT OF L & I AND YOUR WCP SAFETY COORDINATOR CALLED?												

IS THIS THE SAME DESCRIPTION AS EMPLOYEE'S? <input type="checkbox"/> YES <input type="checkbox"/> NO, EXPLAIN												

Corrective Action	WHAT SHOULD BE DONE?								Determine which of the 12 items under E, M, or P (below) require additional attention. <u>Equipment</u> <u>Material</u> <u>People</u> Select Select Select Arrange Place Place Use Handle Train Maintain Process Lead			

	WHO WILL DO IT?											

WHEN WILL IT BE DONE?												

WHAT HAVE YOU DONE THUS FAR?												

Evaluation	IF EMPLOYEE INJURY RESULTED IN SERIOUS INJURY, LOST TIME, DISABILITY OR DEATH, HAVE YOU INITIATED OR PARTICIPATED IN ROOT CAUSE ANALYSIS? IF NOT, WHY?								Take or recommend action, depending upon your authority. Follow-up - was action effective? OBJECTIVE Eliminate job hindrances			

HOW WILL CORRECTIVE ACTION IMPROVE OPERATIONS IN YOUR DEPARTMENT?												

HOW WILL THIS IMPROVE SAFETY?												

IF THE RECOMMENDATIONS INVOLVE PURCHASING EQUIPMENT, ETC., IS BUDGETING A PROBLEM?												

IF PURCHASE IS NOT MADE, WILL INJURIES PERSIST?												

Sign	SUPERVISOR				DATE				COPY FORWARDED TO SAFETY COMMITTEE FOR REVIEW: <input type="checkbox"/> YES <input type="checkbox"/> NO			
	COPY TO MANAGER/DEPARTMENT HEAD				<input type="checkbox"/> YES <input type="checkbox"/> NO				CORRECTIVE ACTION INDICATED? <input type="checkbox"/> YES <input type="checkbox"/> NO			