SUPERVISOR'S INVESTIGATION REPORT
COUNTY OF KERN

Injured Employee: ______________________ (Last, First, Initial) DOB ___/___/___ ID# __________ Male ☐ Female ☐

Home Address: ______________________ (Street) __________ (City and Zip Code) ( ) __________ (Day time phone) __________

Date Injured __________ Time ___:___ AM ☐ PM ☐ Dept. ______________________ Job Title __________
Time employee started work Time ___:___ AM ☐ PM ☐ (Indicate Department, e.g., Probation, DA, Health)

Nature/Extent of injury: ______________________

Engaged in what work when injured? ______________________

Was employee seen by a hospital/doctor? YES ☐ NO ☐ Did employee complete shift? 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 ☐ Amputation	201 ☐ Head (eye, nose, etc.) ______	301 ☐ Burn	401 ☐ Inadequate or no safety guards	501 ☐ Operating without auth.	601 ☐ Minimum Training
102 ☐ Burns	202 ☐ Neck	302 ☐ Exposure	402 ☐ Poor housekeeping	502 ☐ Using defective equip.	602 ☐ Fatigue
103 ☐ Contusion (bruise)	203 ☐ Shoulder ☐ Left ☐ Right	303 ☐ Cut/Puncture	403 ☐ Unsafe/defective equipment	503 ☐ Failure to use safety device or protective equipment	603 ☐ Pre-existing physical weakness
104 ☐ Electrical Shock	204 ☐ Psyche/Mental Disorder	304 ☐ Slip/Trip/Fall	404 ☐ Inadequate illumination or noise control	504 ☐ Failure to make secure	604 ☐ Intoxicated
105 ☐ Foreign Body	205 ☐ Hip ☐ Left ☐ Right	305 ☐ Absorb/Ingest/Inhale	405 ☐ Hazardous personal attire	505 ☐ Improper use of equipment	605 ☐ Inattentive
106 ☐ Fracture	206 ☐ Arm ☐ Left ☐ Right	306 ☐ Stress (mental/heart)	406 ☐ Improper ventilation	506 ☐ Safety rules violated	606 ☐ Nervous, excitable, impatient
107 ☐ Heat	207 ☐ Elbow ☐ Left ☐ Right	307 ☐ Motor Vehicle	407 ☐ Hazardous established procedure	507 ☐ Unsafe loading, placing, carrying, lifting	607 ☐ Lost temper
108 ☐ Hernia	208 ☐ Hand/Wrist ☐ Left ☐ Right	308 ☐ Repetitive Motion	408 ☐ Slippery surface	508 ☐ Took unsafe position/posture	608 ☐ Willful disregard of instructions
109 ☐ Infection	209 ☐ Finger ______	309 ☐ Running or Jumping	409 ☐ Congestion, close clearance	509 ☐ Operating at unsafe speed	609 ☐ Other person
110 ☐ Abrasion	210 ☐ Upper Back	310 ☐ Violence in Workplace	410 ☐ No unsafe condition	510 ☐ Unsafe procedure	610 ☐ No significant personal factor
111 ☐ Bite	211 ☐ Lower Back	311 ☐ Struck by	☐ ______	511 ☐ Horseplay	☐ ______
112 ☐ Laceration (cut)	212 ☐ Leg ☐ Left ☐ Right	312 ☐ Bite or Sting		512 ☐ No unsafe act	
113 ☐ Hypertension	213 ☐ Knee ☐ Left ☐ Right	313 ☐ Lifting Human		☐ ______	
114 ☐ Puncture	214 ☐ Ankle ☐ Left ☐ Right	314 ☐ Lifting Object			
115 ☐ Strain/Sprain	215 ☐ Foot ☐ Left ☐ Right	☐ ______			
116 ☐ Stress	216 ☐ Abdomen				
	217 ☐ Respiratory				

B. WHAT HAPPENED AND WHERE DID IT HAPPEN? WHAT and WHERE: Details of accident and the physical location

If more space needed - use page 2

Witnesses: ______________________

C. CAUSE OF ACCIDENT

WHY and HOW: Acts, failures to act, and/or conditions that most directly contributed to this accident

If more space needed - use page 2

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 - use page 2

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

Supervisor's Signature: ______________________

E. DEPARTMENT HEAD'S CONCURRENCE/COMMENTS

Review for concurrence or return for additional action.

Department Head's Name (Print): ______________________ Date __________

Department Head's Signature: ______________________

SUPERVISOR'S INVESTIGATION REPORT
COUNTY OF KERN

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)

C. CAUSE OF ACCIDENT (continued from page 1)

D. CORRECTIVE ACTION (continued from page 1)

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

IMPORTANT! – DISTRIBUTE TO:

ORIGINAL:	RISK MANAGEMENT LOSS PREVENTION SPECIALIST
ONE COPY:	WORKERS' COMPENSATION SERVICES
ONE COPY:	DEPARTMENT SAFETY COORDINATOR
ONE COPY:	DEPARTMENT FILE