SUPERVISOR'S INVESTIGATION REPORT

COMPANY/SUBSIDIARY	INJURY/ILLNESS INVOLVED? ☐ YES ☐ NO
LOCATION	

ACCIDENT FACTS (*Date, Time, and Shift)*

NAME OF INJURED	INJURED'S DEPARTMENT	INJURED'S OCCUPATION OR JOB

NATURE OF INJURY (*EXTENT OF INJURY AND SPECIFIC BODY MEMBER(S) INJURED)*

DESCRIPTION OF ACCIDENT	WHAT HAPPENED? (*OBSERVE WHERE ACCIDENT OCCURRED, WHAT TASK WAS BEING PERFOMED, DESCRIBE)*
ACCIDENT'S CAUSE(S) (DIRECT AND/OR UNDERLYING)	WHY DID ACCIDENT OCCUR?
CORRECTIVE ACTION REQUIRED	WHAT CORRECTIVE ACTIONS ARE REQUIRED TO PREVENT A RECURRENCE OF THE ACCIDENT? (*WHAT SHOULD BE DONE IMMEDIATELY?)* (*WHAT OTHER FUTURE ACTIONS ARE NEEDED?)*
SCHEDULE FOR CORRECTIVE ACTION	HOW, WHEN AND BY WHOM SHOULD CORRECTIVE ACTION BE TAKEN?

REFERRED TO FOR CORRECTIVE ACTION	TARGET DATE FOR COMPLETION

SIGNATURE (*SUPERVISOR)*	REVIEWED AN APPROVED BY:	DATE OF REPORT