HSC

HSC Risk Management Services
SUPERVISOR'S INCIDENT/ACCIDENT INVESTIGATION REPORT

Investigation should take place as soon as possible to identify causal factors and take corrective steps to prevent a reoccurrence.

PLEASE COMPLETE ALL ITEMS AND PRINT LEGIBILY

1. FACILITY:

ADDRESS:

CITY: **STATE:** **ZIP CODE:**

2 Date of Incident

3. Time ☐ AM ☐ PM

4. Date Reported

5. Employee Name

6. Birthdate

7. Supervisor

Do Not Write In This Space

8. Social Security Number

9. Department

I D#

10 Occupation

11 Was this employee's regular job? ☐ Yes ☐ No

1.

12 Description of Incident

2.

13 Was accident due to malfunction of object or substance?
☐ Yes If yes, explain:
☐ No

3.

4.

14 Nature of Injury

15 Describe treatment

5.

16 Body part affected

17 Name of Healthcare Provider/Professional

Date

6.

18 Type of treatment given
☐ First Aid ☐ Medical Care ☐ None ☐ Refused

19 Expected Loss Time:
☐ None ☐ Less than 7 days ☐ More than 7 days
(Do not include day of incident)

20 Was safety equipment used?
☐ Yes ☐ No
Specify:

8.

9.

21 Was incident due to:
☐ Unsafe act
☐ Unsafe condition
☐ Exposure

22 Was this an OSHA reportable incident? ☐ Yes ☐ No
If yes, post on OSHA Form 300
Reportable Incidents: Record those work-related injuries and illnesses that result in:

- Death
- Loss of consciousness
- Days away from work
- Restricted work activity or job transfer
- Medical treatment beyond first aid
- Needlesticks
- You must also record work related injuries and illness that are significant as defined by OSHA. See OSHA recordkeeping standard.

10.

11.

12.

13.

14.

23 If patient is exposure source:
Name
Hospital
Was lab work done on patient source?
☐ Yes ☐ No If yes. specify:

24 Exposure due to:
☐ Blood/body fluids Other - Specify:
☐ Chemical/chemical vapors
☐ Infectious disease

25 Does your facility have a safety committee?
☐ Yes ☐ No
If yes, have they investigated the incident?
☐ Yes ☐ No

15.

Office Use Only

26 Causal analysis:

27 Recommendations to prevent a reoccurrence

28 Name of witnesses

1291 Investigator's signature Date

Employee's signature Date

Please complete and return to:
HSC Risk Management Services,

PO Box 92200
Albuquerque, NM 87199-2200
Ph: 505-343-0070 / 800-577-2121 Fax: 505-343-9074
Internal: *cc Claims Manager*

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of the employee to the extent possible while the information is being used for occupational safety and health purposes.