NSHE | BCN HR Shared Services | Workers' Compensation Office

Supervisor Accident/Injury/Incident Investigative Report

Department: **Employee Name:**

Department Location: **Job Title:**

Date of Incident/Injury: **Length of time in Position:**

Employment Status: ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Temporary ☐ Volunteer

Was employee performing regular job functions? ☐ Yes ☐ No

If not, explain:

Physical Demand: ☐ Very heavy work ☐ Heavy work ☐ Medium work ☐ Light work ☐ Sedentary work

Was employee working overtime? ☐ Yes ☐ No

If yes, explain:

Notice of Injury "C-1" form completed: ☐ Yes ☐ No

Injury reported to: **Date reported:**

Location of Accident/Incident: **Time of Accident/Incident:**

Body Part/s injured: **Type of injury:**

Severity of Injury/Action Taken:

☐ No action taken ☐ First Aid ☐ Dr. Visit ☐ Urgent Care ☐ ER Visit

Does the employee have restricted duty? ☐ Yes ☐ No **Did the employee lose time from work?** ☐ Yes ☐ No

Describe in detail what happened:

Has the employee receiving training for this type of incident? ☐ Yes ☐ No If yes, when?

Describe any equipment damage and associated costs?

Witnesses

*Please include written statements. If non-State employee, include work or home address.

Witness #1: Job Title: Telephone:

Witness #2: Job Title: Telephone:

Witness #3: Job Title: Telephone:

Causes of Accident/Injury: Section 1

Select all that apply.

Environmental

- ☐ Weather conditions
- ☐ Heat
- ☐ Cold
- ☐ Noise
- ☐ Smoke/Fumes
- ☐ Dust
- ☐ Other

Work Conditions

- ☐ Defective Equipment/Tools
- ☐ Poor housekeeping/clutter
- ☐ Inadequate Workspace
- ☐ Uneven/Wet Walking Surface
- ☐ Inadequate Protection Equipment
- ☐ Inadequate Lighting
- ☐ Inadequate Ventilation
- ☐ Other

Personal Factors

- ☐ Unsafe Act
- ☐ Lack of Knowledge/Skill
- ☐ Improper Motivation
- ☐ Inadequate Planning
- ☐ Fatigue/Stress
- ☐ Deviation from Procedure
- ☐ Violation of Safety Rule
- ☐ Other

Causes of Accident/Injury: Section 2

Select all that apply.

Job Factors

- ☐ Poor Work Area Set up/Design
- ☐ Improper or Inadequate Equipment/Tools
- ☐ Lack of Procedures/Safety Rules
- ☐ Maintenance Issues
- ☐ Inadequate Safety Inspections
- ☐ Inadequate Resources

Management Issues

- ☐ Insufficient Planning
- ☐ Budgetary Constraints
- ☐ Insufficient Training
- ☐ Safety Issue Not Prioritized/Emphasized
- ☐ Insufficient Enforcement of Safety Rules
- ☐ Understaffed

Causes of Accident/Injury: Section 3 (Complete only for slips, trips, and falls – required)

*Please include a photograph of the specific location and anything that may have caused the slip, trip, or fall.

Was there a specific hazard that may have caused the injury/accident? ☐ Yes ☐ No

If yes, explain:

Did the employee's footwear contributed to the accident/injury? ☐ Yes ☐ No

Is the location specific to the employee's immediate work area? ☐ Yes ☐ No

If yes, how often does the employee walk through the area on an average day?

Is this location accessed by the public? ☐ Yes ☐ No

Corrective Action Plan (Include immediate, short term, and long term plan)

Immediate Action

Assigned To: Date Completed:

Short Term Plan

Assigned To: Date Completed:

Long Term Plan

Assigned To: Date Completed:

Printed Name:

Signature: **Date:**

The corrective action plan should be directed toward preventing future accidents that are similar in nature by the employee above or by other employees that share related duties.

Please submit form to Workers Compensation Department via fax at (775) 784-4363 or via e-mail at BCNRisk@unr.edu.