CITY OF STOCKTON

SUPERVISOR'S INVESTIGATION REPORT
CITY OF STOCKTON

For Instructions See **INSTRUCTIONS FOR FORM COMPLETION**

Injured Employee: _____ DOB _____ SS# _____ Male ☐ Female ☐

Home Address: _____ (Street) _____ (City) ( ) _____ (Phone Number) _____ (Date of Hire)

Date Injured _____ Time : AM ☐ PM ☐ Dept. _____ Job Class _____

Time employee started work Time : AM ☐ PM ☐ (Indicate Main Department, e.g., Police, CDD)

Date Injury Reported _____ Time Injury Reported : AM ☐ PM ☐

Nature/Extent of injury: _____

Engaged in what work when injured? _____

Was medical treatment offered? YES ☐ NO ☐ Was employee seen by a hospital/doctor? 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

- 101 ☐ Cut/puncture
- 102 ☐ Strain/Sprain
- 103 ☐ Contusion (bruise)
- 104 ☐ Burn (heat or chemical)
- 105 ☐ Fracture
- 106 ☐ Crush Injury
- 107 ☐ Dislocation
- 108 ☐ Skin Irritation
- 109 ☐ Infection
- 110 ☐ Effects of environment
- 111 ☐ Foreign object
- 112 ☐ Splash
- 113 ☐ Other

PART OF BODY

- 201 ☐ Head
- 202 ☐ Face
- 203 ☐ Eye ☐Left ☐Right
- 204 ☐ Neck
- 205 ☐ Shoulder ☐Left ☐Right
- 206 ☐ Arm ☐Left ☐Right
- 207 ☐ Elbow ☐Left ☐Right
- 208 ☐ Hand ☐Left ☐Right
- 209 ☐ Finger
- 210 ☐ Back & spine
- 211 ☐ Trunk (including hips)
- 212 ☐ Leg ☐Left ☐Right
- 213 ☐ Knee ☐Left ☐Right
- 214 ☐ Ankle ☐Left ☐Right
- 215 ☐ Foot ☐Left ☐Right
- 216 ☐ _____

ACCIDENT TYPE

- 301 ☐ Slip/fall same level
- 302 ☐ Slip/fall different level
- 303 ☐ Struck against
- 304 ☐ Struck by
- 305 ☐ Caught in between
- 306 ☐ Strain/overexertion
- 307 ☐ Inhale, Absorb, Ingest
- 308 ☐ Electrical
- 309 ☐ Temperature extreme
- 310 ☐ Attack/assault
- 311 ☐ Bite or sting
- 312 ☐ Horseplay
- 313 ☐ Vehicular
- 314 ☐ Cut/Puncture
- 315 ☐ _____

UNSAFE CONDITION

- 401 ☐ Inadequate or no safety guards
- 402 ☐ Poor Housekeeping
- 403 ☐ Unsafe/defective equipment
- 404 ☐ Inadequate illumination or noise control
- 405 ☐ Hazardous personal attire
- 406 ☐ Improper ventilation
- 407 ☐ Hazardous established procedure
- 408 ☐ Slippery Surface
- 409 ☐ Congestion, close clearance
- 410 ☐ No unsafe condition
- 411 ☐ _____

UNSAFE ACT

- 501 ☐ Operating without auth.
- 502 ☐ Using defective equip.
- 503 ☐ Failure to use safety device or protective equipment
- 504 ☐ Failure to make secure
- 505 ☐ Improper use of equipment
- 506 ☐ Safety rule was violated
- 507 ☐ Unsafe loading, placing, carrying, lifting
- 508 ☐ Took unsafe position/ posture
- 509 ☐ Operating at unsafe speed
- 510 ☐ Unsafe procedure
- 511 ☐ Horseplay
- 512 ☐ No unsafe act
- 512 ☐ _____

CONTRIBUTING CAUSE (Indirect)

- 601 ☐ Minimum training
- 602 ☐ Fatigue
- 603 ☐ Pre-existing physical weakness
- 604 ☐ Intoxicated
- 605 ☐ Inattentive
- 606 ☐ Nervous, excitable, impatient
- 607 ☐ Lost temper
- 608 ☐ Willful disregard of instructions
- 609 ☐ Other person
- 610 ☐ No significant personal factor
- ☐ _____

B. WHAT HAPPENED AND WHERE DID IT HAPPEN? Include missing details uncovered by your investigation. Furnish the following: WHAT happened and the physical location WHERE it happened

If more space needed --press the TAB key, and answer YES either before or when no more typing is permitted (400 characters)

Witnesses: _____

C. CAUSE OF ACCIDENT What acts, failures to act and/or conditions contributed most directly to accident – the WHY & HOW

If more space needed --press the TAB key, and answer YES either before or when no more typing is permitted (400 characters)

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 --press the TAB key, and answer YES either before or when no more typing is permitted (400 characters)

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

Supervisor's Signature: _____ **Telephone #** _____

E. DEPARTMENT HEAD'S CONCURRENCE/COMMENTS Review for concurrence or return for additional action.

Department Head's Name (Print): _____ Date _____

Department Head's Signature: _____

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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)

When completed, press the TAB key to move back to item C on first page

C. CAUSE OF ACCIDENT (continued from page 1)

When completed, press the TAB key to move back to item D on first page

D. CORRECTIVE ACTION (continued from page 1)

When completed, press the TAB key to move back to "Date Form Completed" on first page

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

When completed, press the TAB key to move back to "Date Form Completed" on first page

IMPORTANT! – PLEASE DISTRIBUTE TO:

Original - City Safety Officer **One Copy** - Department File

One Copy - Department Safety Coordinator