H A M P S H I R E C O L L E G E

SUPERVISOR ACCIDENT INVESTIGATION REPORT

(To be completed by the Supervisor with employee input)

Today's Date:	Date/Time of Injury:
Injured Employee:	Occupation:
Department:	Supervisor:

MEDICAL AND LOST TIME STATUS		
☐ Lost Time	☐ Medical Only	☐ Report Only
If Lost Time, last day worked:		
If Lost Time, has employee returned to work?	☐ Yes	☐ No
If yes, date returned:		
Was first aid administered:	☐ Yes	☐ No
If yes, describe:		
Was employee treated in the emergency room? Which hospital?	☐ Yes	☐ No
Was employee hospitalized overnight?	☐ Yes	☐ No
List Witnesses:		

DESCRIPTION OF INJURY
Describe injury including body part(s) and type of injury:

ACCIDENT LOCATION
Describe (if location contributed to the accident, please be specific:

ACCIDENT INFORMATION Please answer the following questions and provide any additional information describing how the accident or injury occurred.
What was the employee doing?
Was the employee following established work procedures (e.g., proper lifting)? Describe.
Was the work a routine task or something the employee has not done before or does infrequently?
If the employee was carrying materials, what were they, how heavy were they, should the employee have asked for help?
If environmental factors (e.g., temperature, snow/ice, lighting) contributed to the accident, what were they and how did they contribute?

If you need medical attention, please go to Occupational Health Services, 413.582.2480, M-F, 8:30-4:30
All other times go to Cooley Dickinson Hospital Emergency Room.

What other conditions in the workplace (e.g., tools, walking surfaces, vehicles) contributed to the accident?
Was personal protective equipment (e.g., goggles, gloves, proper footwear) being used? If not, should it have been?
What employee actions (e.g., rushing, choosing the wrong tool) contributed to the accident?
Additional Information:

WHAT WAS THE PRIMARY CAUSE OF THIS ACCIDENT?			
Describe:			
Classify			
☐ Unsafe Condition (an identifiable hazard)	☐ Unattentive (distracted or not paying attention)	☐ Repetitive Motion (an activity performed over and over again)	☐ Unsafe Act (not following established work practices or reasonable conduct)
☐ Other (Describe)	If other, describe:		

RECOMMENDATIONS FOR PREVENTING SIMILAR ACCIDENTS
Describe:
Is additional training/coaching needed?
Do established work procedures need to be changed?
Is a work order needed to correct a hazard?

HAS RECOMMENDED ACTION BEEN TAKEN?
☐ Yes ☐ No
If not, why, when will it be?

Name of Supervisor Completing this Report:	Date:
For all Lost Time Accidents, this Report must also be Reviewed by the Department Head Name of Department Head Reviewing this Report:	Date: