# Supervisors Incident Report

(Include Accidents, Exposure to Hazardous Substance or Disease)

☐ FOR INFORMATION ONLY

**(1) PLEASE PRINT**

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

SOCIAL SECURITY # _____ HOME PHONE _____

NAME/PHONE OF EMPLOYER _____

**(2) YRS EMPLOYED**

☐ Under ½ Year
☐ ½ - 4 Years
☐ 5 - 10 Years
☐ Over 10 Years

**(3) SEX**

☐ MALE ☐ FEMALE

**(4) AGE**

_____

**(5) DATE OF INCIDENT**

Day of Week _____ / _____ / _____

**(6) TIME OF INCIDENT**

AM PM

**(7) DESCRIPTION OF INCIDENT**

_____

_____

**(8) INCIDENT ON EMPLOYER PREMISES?**

☐ YES ☐ NO If No Where? _____

**(9) DATE REPORTED**

_____ / _____ / _____

**(10) WHERE DID INCIDENT HAPPEN?**

**(11) SUPERVISOR NOTIFIED AT TIME OF INCIDENT**

☐ YES ☐ NO

Name _____

**(12) MEASURES TAKEN TO PREVENT REOCCURRENCE**

_____

_____

**(13) TYPE OF INJURY** ✓ All That Apply

☐ No Apparent Injury
☐ Laceration/Abrasion
☐ Puncture
☐ Burn
☐ Bruise/Crush
☐ Bite/Scratch
☐ Electrical Shock
☐ Foreign Body
☐ Strain/Sprain
☐ Fracture
☐ Amputation
☐ Infection
☐ Other
Explain: _____

**(14) PART OF BODY** ✓ All That Apply

| Left | Right | |
|---|---|---|
| ☐ | ☐ | Head |
| ☐ | ☐ | Eye |
| ☐ | ☐ | Face |
| ☐ | ☐ | Neck |
| ☐ | ☐ | Chest |
| ☐ | ☐ | Abdomen |
| ☐ | ☐ | Back |
| ☐ | ☐ | Arm |
| ☐ | ☐ | Shoulder |
| ☐ | ☐ | Elbow |
| ☐ | ☐ | Hand |
| ☐ | ☐ | Finger(s) |
| ☐ | ☐ | Wrist |

| Left | Right | |
|---|---|---|
| ☐ | ☐ | Leg |
| ☐ | ☐ | Groin |
| ☐ | ☐ | Knee |
| ☐ | ☐ | Foot |
| ☐ | ☐ | Toe(s) |
| ☐ | ☐ | Ankle |

**(15) Previous Injury, same part?**

☐ Yes ☐ No
Date ____ / ____ / ____
Describe: _____

**(16) POSSIBLE CAUSES** ✓ All That Apply

☐ Unclear as to Policy/Procedure
☐ Unaware of Safety Hazard
☐ Poor Illumination
☐ Foreign Material on Floor
☐ Building/Premises Defect
☐ Improper Body Mechanics
☐ Improper Clothing/Equipment
☐ Equipment Defect/Malfunction/Handling
☐ Patient Initiated Occurrence
☐ Other
Explain: _____

**(17) DEPT/JOB INVOLVED**

DEPT _____ Full Time _____
Job Title _____ Part Time _____

**(18) SUPERVISOR'S COMMENTS**

_____

_____

_____

**(19) WITNESSED BY (Please Print)**

Name _____
( ) _____
Home Telephone

Name _____
( ) _____
Home Telephone

**(20) TREATMENT**

☐ No Treatment Necessary
☐ First-Aid
☐ Employee Health
☐ Emergency Room
Hospital _____
☐ Refused Treatment
☐ Other
Explain: _____

Briefly Describe Treatment _____

**Referred To Panel Physician ☐ Yes ☐ No**
Name _____ Rendered By: _____

**(21) DISPOSITION**

☐ Returned to Work
☐ Release to Home
☐ Hospitalized
☐ Fatality
☐ Other (explain)
☐ Time Lost ☐ No ☐ Yes _____ Estimated Absence

**(22) SIGNATURES**

_____ / / _____
Employee Date

_____ / / _____
Supervisor Date

Reviewer Comments: _____

Brentwood Services Administrators, Inc.

Pink - BSA, Inc. Routing White & Yellow - Facility