C O L B Y

SUPERVISOR'S FIRST REPORT OF INJURY

Must be submitted to Personnel Office Within 24 hours from time of injury

NAME OF INJURED EMPLOYEE	EMPLOYEE HOME PHONE	SOCIAL SECURITY NO.

ADDRESS	DATE OF BIRTH

DATE OF EMPLOYMENT	OCCUPATION	DEPARTMENT	DATE AND TIME OF EMPLOYEE REPORT TO SUPERVISOR
/ /			

WAS REPORT TO SUPERVISOR OR FIRST AID DELAYED? (IF YES, PLEASE EXPLAIN)	DATE	TIME
	/ /	❑ AM ❑ PM

WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY?	TIME EMPLOYEE'S WORK DAY BEGAN	DID EMPLOYEE LOSE ONE OR MORE DAYS OF WORK?	HAS EMPLOYEE RETURNED TO WORK?	IF YES, GIVE DATE:
❑ YES ❑ NO	❑ AM ❑ PM	❑ YES ❑ NO	❑ YES ❑ NO	/ /

NATURE AND EXTENT OF INJURY OR ILLNESS (CHECK APPROPRIATE BOXES AND EXPLAIN BELOW)

LEFT	RIGHT				MEDICAL TREATMENT	INJURED SENT/WENT
❑ EYE	❑ EYE	❑ NECK	❑ SORENESS	❑ BURNS	❑ FIRST AID ONLY	❑ HOME
❑ ARM	❑ ARM	❑ BACK	❑ LACERATIONS	❑ FOREIGN BODY	❑ MEDICAL ONLY	❑ DOCTOR'S OFFICE
❑ EAR	❑ EAR	❑ HEAD	❑ STRAINS/SPRAINS	❑ SKIN (RASH, ERUPTIONS, ETC.)	❑ LOST TIME	❑ HOSPITAL
❑ HAND	❑ HAND	❑ TRUNK	❑ FRACTURES	❑ CHEMICAL EXPOSURE	❑ ALLEGED	❑ HEALTH CENTER
❑ LEG	❑ LEG	❑ INTERNAL	❑ BRUISES	❑ OTHER (DESCRIBE BELOW)	❑ NO TREATMENT	❑ OTHER
❑ TOES	❑ TOES	❑ OTHER				

DATE OF INJURY OR FIRST SYMPTOMS	HOUR	PLACE WHERE INJURED (MOTOR VEHICLE, BUILDING, ETC.)	EXACT LOCATION (WALKWAY AT SOUTH END, ETC.)
/ /	❑ AM ❑ PM		

EYEWITNESS 1.	EYEWITNESS 2.	EYEWITNESS 3.

DESCRIBE ACCIDENT, INCLUDE THE MACHINE, OBJECT, OR SUBSTANCE INVOLVED… ALL DETAILS…USE BACK OF WHITE COPY (PART 1) FOR FURTHER EXPLANATIONS

____

____

____

____

____

CASUE (CHECK ALL THAT APPLY)

UNSAFE ACTS		UNSAFE CONDITIONS	
❑ OPERATING WITHOUT AUTHORITY	❑ TAKING UNSAFE POSITION	❑ INADEQUATELY GUARDED	❑ HAZARDOUS ARRANGEMENTS
❑ OPERATION AT UNSAFE SPEEDS	❑ WORKING ON MOVING OR DANEROUS EQUIPMENT	❑ UNGUARDED	❑ UNSAFE ILLUMINATION
❑ MAKING SAFETY DEVICES INOPERATIVE	❑ DISTRACTION, TEASING, HORSEPLAY	❑ DEFECTIVE TOOLS, EQUIPMENT, OR SUBSTANCE	❑ UNSAFE VENTILATION
❑ USING UNSAFE EQUIPMENT/ USING EQUIPMENT UNSAFELY	❑ FAILURE TO USE PERSONAL PROTECTIVE DEVICES	❑ UNSAFE DESIGN OR CONSTRUCTION	❑ UNSAFE CLOTHING
❑ UNSAFE LOADING, PLACING, MIXING	❑ OTHER ______________________		❑ OTHER ____________________

BASED ON THE CAUSE(S) CHECKED ABOVE, INDICATE THE CORRECTIVE ACTION YOU ARE TAKING

UNSAFE ACTS	UNSAFE CONDITIONS	
❑ STOP THE WORKER	❑ ELIMINATE	❑ FOLLOW UP:
❑ STUDY THE JOB	❑ GUARD	
❑ RE-TRAIN	❑ WARN	
❑ FOLLOW-UP	❑ RECOMMEND TO: (CIRCLE)	
❑ DISCIPLINE (INDICATE TYPE)______________________	OWN SUPERVISOR DEPARTMENT HEAD SAFETY COMMITTEE	

WHAT ARE YOU DOING TO PREVENT SIMILAR INJURIES? ______________________________

____

____

____

ANY FURTHER RECOMMENDATIONS? ______________________________

____

____

SUPERVISOR (PLEASE PRINT)	SIGNATURE	DATE	WORK PHONE
		/ /	

NOTE: EMPLOYEE TO SUBMIT WRITTEN AND SIGNED EXPLANATION OF INURY/INCIDENT ATTACHED TO THIS FORM