The Supervisor must complete this form with the employee and then forward it to the Human Resources office, along with the 207 report, within 24 hours after the incident.

GENERAL INFORMATION Employee Name Date of Incident Location of Incident Time of Incident Medical Treatment? Job Title DFR First Aid **D**None Ambulance Other UWalk-In Nature of Injury **INCIDENT DESCRIPTION:** TYPE OF INCIDENT: (check most appropriate, define other if checked) Assault by public Slip/Trip/Fall Cut/laceration/puncture Lifting/Material Handling Caught in/on/between Exposure (air quality, etc.) Shoved by or against an object Foreign body in eye Other Cumulative trauma Contact with heat/cold/chemical Motor Vehicle Accident Repetitive motion CAUSES/CONTRIBUTING FACTORS Check all that apply CONDITIONS BEHAVIORS Hazardous process Poor lighting Failure to follow safety procedure Unsafe body mechanics Weather conditions Poor design Failure to use PPE Employee attitude on safety Equipment not available Carpet/mat Improper technique Horseplay Poor housekeeping Chemicals/cleaning agents Using equipment unsafely Failure to use lookout/tagout Equipment malfunction Improper PPE Inappropriate dress or footwear Inattention/disfunction Ergonomic set-up Lack of training Failure to obtain assistance Poor judgement responding Floor/ground condition UWorking at unsafe speed to unsafe condition Performing task without knowledge/failure to ask Other Failure to recognize unsafe condition Not in scope of duties ACTION PLAN TO PREVENT RECURRENCE Additional training Hepatitus B vaccine Reinforce employee accountability for safety Renew bloodborne training Monitor work practices Renew hazmat training Work orders written Ergonomic set-up evaluation Maintenance work order written Air quality consultation Procedures revised MVA= Local or State Investigation Referrals made Other Apply OSHA program and manuals MANAGER SIGNATURE: PRINT NAME: DATE: SUPERVISOR SIGNATURE: PRINT NAME: DATE:

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