☐ Amended

Supervisor's Investigation Report

See Management Directive 1030 for additional information

EMPLOYEE INFORMATION:			
			☐ MALE
NAME OF INJURED EMPLOYEE:	SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	☐ FEMALE
HOME ADDRESS (STREET, CITY, STATE, AND ZIP):		PHONE NUMBER:	
PEOPLESOFT ID:	DATE OF HIRE:	COUNTY DEPARTMENT:	JOB TITLE:

INJURY INFORMATION:		
Date employee first reported incident to Supervisor:	**MEDICAL TREATMENT AND OJI PACKET MUST BE OFFERED IN ONE BUSINESS DAY OF KNOWLEDGE OF THE INJURY TO AVOID FINES.**	
Date medical treatment and OJI packet offered:		
Did the employee indicate they want to file a claim (accepted the packet)? ☐ Date:		(DWC-1, ITEMS 12 AND 13) IF DECLINED AND LATER ACCEPTED, LIST BOTH DATES.
Did the employee indicate they do NOT want to file a claim (declined the packet)? ☐ Date:		

IF UNABLE TO CONTACT THE EMPLOYEE IMMEDIATELY, COMPLETE AND SUBMIT THIS FORM AND REVISE WHEN POSSIBLE.

DATE OF INJURY:	TIME OF INJURY:	TIME EMPLOYEE STARTED WORK:
	AM ☐ PM ☐	AM ☐ PM ☐

Address/physical location where the injury/illness occurred:			
Was employee transported by ambulance to hospital? Yes ☐ No ☐	Admitted overnight? Yes ☐ No ☐	# of lost workdays:	

IN THE EVENT OF AMBULANCE TRANSPORT OR HOSPITALIZATION PLEASE ALSO COMPLETE THE EMPLOYEE FATALITY AND SERIOUS INJURY REPORT AND CONTACT DEPARTMENT PERSONNEL & RISK MANAGEMENT IMMEDIATELY.

The medical facility/doctor/hospital where the employee was treated:			
Was a police report filed? Yes ☐ No ☐	Report Number:	Law Enforcement Agency:	
Did anyone witness the injury/illness? Yes ☐ No ☐			
Witness #1 Information:	Witness #2 Information:	Witness #3 Information:	Witness #4 Information:
Name:	Name:	Name:	Name:
Phone #:	Phone #:	Phone #:	Phone #:
Does the employee have a prior claim related to this injury? Yes ☐ No ☐			

TYPE OF INJURY	PART OF BODY	ACCIDENT TYPE	UNSAFE CONDITION	UNSAFE ACT	CONTRIBUTING CAUSE
☐ 101 Cut/puncture	☐ 201 Head	☐ 301 Slip/fall same level	☐ 401 Inadequate or no safety guards	☐ 501 Operating without auth.	☐ 601 Minimum training
☐ 102 Strain/Sprain	☐ 202 Face	☐ 302 Slip/fall different level	☐ 402 Poor Housekeeping	☐ 502 Using defective equip.	☐ 602 Fatigue
☐ 103 Contusion (bruise)	☐ 203 Eye ☐ Left ☐ Right	☐ 303 Struck against	☐ 403 Unsafe/defective equipment	☐ 503 Failure to use safety device or protective equipment	☐ 603 Pre-existing physical weakness
☐ 104 Burn (heat or chemical)	☐ 204 Neck	☐ 304 Struck by	☐ 404 Inadequate illumination or noise control	☐ 504 Failure to make secure	☐ 604 Intoxicated
☐ 105 Fracture	☐ 205 Shoulder ☐ Left ☐ Right	☐ 305 Caught in between	☐ 405 Hazardous personal attire	☐ 505 Improper use of equipment	☐ 605 Inattentive
☐ 106 Crush Injury	☐ 206 Arm ☐ Left ☐ Right	☐ 306 Strain/overexertion	☐ 406 Improper ventilation	☐ 506 Safety rule was violated	☐ 606 Nervous, excitable, impatient
☐ 107 Dislocation	☐ 207 Elbow ☐ Left ☐ Right	☐ 307 Inhale, Absorb, Ingest	☐ 407 Hazardous established procedure	☐ 507 Unsafe loading, placing, carrying, lifting	☐ 607 Lost temper
☐ 108 Skin Irritation	☐ 208 Hand ☐ Left ☐ Right	☐ 308 Electrical	☐ 408 Slippery Surface	☐ 508 Took unsafe position/ posture	☐ 608 Willful disregard of instructions
☐ 109 Infection	☐ 209 Finger	☐ 309 Temperature extreme	☐ 409 Congestion, close clearance	☐ 509 Operating at unsafe speed	☐ 609 Other person
☐ 110 Effects of environment	☐ 210 Back & spine	☐ 310 Attack/assault	☐ 410 No unsafe condition	☐ 510 Unsafe procedure	☐ 610 No significant personal factor
☐ 111 Foreign object	☐ 211 Trunk (including hips)	☐ 311 Bite or sting	☐ 411 Other unsafe condition	☐ 511 Horseplay	
☐ 112 Splash	☐ 212 Leg ☐ Left ☐ Right	☐ 312 Horseplay		☐ 512 No unsafe act	☐ 611 Other cause
☐ 113 Infectious Disease	☐ 213 Knee ☐ Left ☐ Right	☐ 313 Vehicular		☐ 513 Other unsafe act	
☐ 114 Other injury	☐ 214 Ankle ☐ Left ☐ Right	☐ 314 Cut/Puncture			
	☐ 215 Foot ☐ Left ☐ Right	☐ 315 Other accident type			
	☐ 216 Other body part				

IF THE INCIDENT INVOLVES POTENTIAL EXPOSURE TO AN INFECTIOUS DISEASE, PLEASE REFER TO THE COMMUNICABLE DISEASE EXPOSURE REPORT AND SUBMIT TO RISK MANAGEMENT AND THE DEPARTMENT EXPOSURE CONTROL OFFICER IMMEDIATELY.

A. DESCRIBE THE TYPE OF INJURY. (IF MORE SPACE IS NEEDED FOR FIELDS A-G, ATTACH ADDITIONAL PAGES)

SUPERVISOR'S INVESTIGATION REPORT CONTINUED ON PAGE 2

B. WHAT HAPPENED?

C. WHAT BODY PARTS WERE AFFECTED?

D. ARE YOU QUESTIONING THE INJURY/ILLNESS? Yes ☐ No ☐ If yes, indicate why in the space below.

E. CAUSE OF ACCIDENT.

F. WHAT PREVENTATIVE MEASURES OR CORRECTIVE ACTIONS HAVE BEEN RECOMMENDED TO PREVENT RECURRENCE?

Investigator's Name:		**Investigator's Phone Number:**	
Investigator's Signature		**Date of Investigator's Signature**	

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

Department Head's Name:		**Department Head's Phone Number:**	
Department Head's Signature		**Date of Department Head's Signature**	

IMPORTANT INSTRUCTIONS! SEND TO: DEPARTMENT PERSONNEL & HRRISKWORKERSCOMP@FRESNOCOUNTYCA.GOV WITHIN 24 HOURS OF NOTICE OF INCIDENT. IF OJI CLAIM IS FILED, SEND SIR WITH OJI FORMS.