CITY OF NEW BERN

SUPERVISOR'S INJURY AND ILLNESS INCIDENT REPORT

Complete and return to the Safety Officer within 24 hours of the event.

EMPLOYEE INFORMATION (PLEASE TYPE OR PRINT)

Full Name:_____ Date of Birth:_____ Male____ Female____

Home Address:_____

Home Phone: _____ Work Phone: _____ Date of Hire:_____

Job Title: _____ Employment Status: _____

EMPLOYER INFORMATION

Department/Division: _____

Supervisor's Name: _____ Phone Number: _____

INCIDENT/INJURY INFORMATION

Date of Incident: _____ Time:_____ Employer's Premises? ☐ Yes ☐ No

Incident Address: _____ County: _____

Time Employee Began Work: _____ Date Supervisor Notified: _____ Time: _____

Name of Physician or Health Care Professional: _____

Name of Health Care Facility:_____ Phone: _____

Facility Address: _____

Was the employee treated in the Emergency Room? ☐ Yes ☐ No

Was the employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

Did the event result in a fatality? ☐ Yes ☐ No Date of Fatality: _____

Date the Employee Returned to Work: _____ Time: _____

Witnesses (Include phone number): _____

_____ *All persons who observed the incident or the events leading up to the incident are considered witnesses. Each witness shall complete a written statement on the City of New Bern Witness Statement Form. Please attach the completed Witness Statement Forms to this report.*

Describe the Incident
Describe the events leading up to the incident: (Describe the activity including tools, equipment, or material the employee was using). Attach additional pages if necessary.
Describe how the injury occurred:

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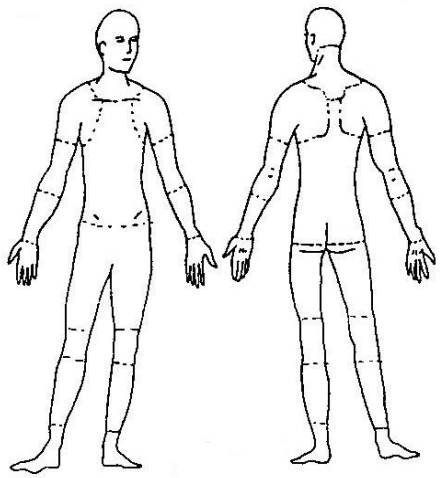
What object or substance directly harmed the employee? (examples: concrete floor, chlorine, radial arm saw)

What personal protective equipment was being used (if any)?

Was the employee trained to perform this activity including equipment training? ❑ Yes ❑ No (attach documents)

Body Parts Affected

Part of body affected: (shade all that apply)



Nature of injury: (most serious one)

- ☐ Abrasion, scrapes
- ☐ Amputation
- ☐ Broken bone
- ☐ Bruise
- ☐ Burn (heat)
- ☐ Burn (chemical)
- ☐ Concussion (to the head)
- ☐ Crushing Injury
- ☐ Cut, laceration, puncture
- ☐ Hernia
- ☐ Illness
- ☐ Sprain, strain
- ☐ Damage to a body system:
- ☐ Other _____

This employee works:

- ☐ Regular full time
- ☐ Regular part time
- ☐ Seasonal
- ☐ Temporary

Months working in current position:

Months performing this activity:

Why did the incident happen?

Was there an unsafe condition that contributed to the incident? If so explain.

90 to 95% off all workplace injuries are the result of an unsafe act. Describe the unsafe acts that caused the injury?

How can future incidents be prevented?

What changes do you suggest to prevent this incident/near miss from happening again?

☐ Stop this activity ☐ Guard the hazard ☐ Train the employee(s) ☐ Train the supervisor(s)
☐ Redesign task steps ☐ Redesign work station ☐ Write a new policy/rule ☐ Enforce existing policy
☐ Routinely inspect for the hazard ☐ Personal Protective Equipment ☐ Other: _____

What should be (or has been) done to carry out the suggestion(s) checked above?

Supervisor Signature: _____ Date _____ Phone _____

Safety Officer Review: _____ Date _____ Phone _____