Supervisor's Investigation Report

See Management Directive 1030 for additional information

[Email Me]
Double click!

INSTRUCTIONS: WITHIN *ONE BUSINESS DAY* OF NOTICE OF INCIDENT, SEND TO YOUR DEPARTMENT'S PERSONNEL UNIT & HRRISKWORKERSCOMP@FRESNOCOUNTYCA.GOV IF AN OJI CLAIM IS FILED, SEND SIR FORM WITH OJI FORMS IN THE SAME TIMEFRAME.

SHOULD NEW INFORMATION ARISE, THEN THIS REPORT MAY BE AMENDED. INDICATE THE CURRENT VERSION INFORMATION BELOW:

ORIGINAL REPORT ☐ **AMENDED REPORT ☐** **DATE THIS VERSION WAS COMPLETED:**

INJURED WORKER INFORMATION:

COMPLETE THE INFORMATION BELOW TO THE BEST OF YOUR ABILITY, SUBMITTING TO RISK MANAGEMENT AND YOUR DEPARTMENT'S PERSONNEL UNIT WITHIN ONE BUSINESS DAY OF KNOWLEDGE OF THE INCIDENT.

NAME OF INJURED WORKER:	HOME ADDRESS (STREET, CITY, STATE, AND ZIP):	PHONE NUMBER:

COUNTY EMPLOYEE:

PEOPLESOFT ID:	DATE OF HIRE:	JOB TITLE:	COUNTY DEPARTMENT:

COUNTY VOLUNTEER OR ADULT OFFENDER WORK PROGRAM PARTICIPANT (IF APPLICABLE):

COUNTY VOLUNTEER ☐ ADULT OFFENDER WORK PROGRAM (AOWP) PARTICIPANT ☐

START DATE:	FREQUENCY OF VOLUNTEER PARTICIPTION:	COUNTY DEPARTMENT:

INJURY INFORMATION:

COMPLETE AND SUBMIT THIS FORM WITHIN ONE BUSINESS DAY OF KNOWLEDGE OF THE INCIDENT, EVEN IF YOU ARE UNABLE TO CONTACT THE EMPLOYEE. YOU WILL HAVE THE OPPORTUNITY TO REVISE SHOULD NEW INFORMATION BE PROVIDED.

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

Does the employee have an existing claim related to this injury? YES ☐ NO ☐ UNKNOWN ☐

LOCATION OF INJURY: *List the address and/or physical location where the injury/illness occurred. Please be as specific as possible.*

THE OJI PACKET, INCLUDING THE MEDICAL TREATMENT AUTHORIZATION FORM, MUST BE OFFERED WITHIN *ONE BUSINESS DAY* OF KNOWLEDGE OF THE INJURY. THESE FORMS CAN BE FOUND IN THE E-SERVICES FORMS LIBRARY.

Date employee first reported incident to Supervisor:

Date medical treatment and OJI packet offered:

IF PACKET IS DECLINED AND LATER ACCEPTED, **LIST BOTH DATES.**	
	☐ Check if the employee initially indicated they WANT to file a claim (accepted the packet). Date:
	☐ Check if the employee initially indicated they do NOT want to file a claim (declined the packet). Date:
	☐ Check if the employee initially declined the packet and later accepted, choosing to file a claim. Date:

Was employee transported by ambulance to hospital? YES ☐ NO ☐ Admitted overnight? YES ☐ NO ☐ Number of lost workdays:

Did Cal/OSHA need to be notified of this injury? YES ☐ NO ☐ Date Cal/OSHA was notified, if applicable?

The medical facility/doctor/hospital where the employee was treated:

Was a police report filed? YES ☐ NO ☐ Report Number: Law Enforcement Agency:

INJURIES AND CIRCUMSTANCES THAT REQUIRE ADDITIONAL ACTION:

WHEN WORKERS EXPERIENCE AMBULANCE TRANSPORTATION AND/OR POTENTIAL HOSPITALIZATION: IMMEDIATELY COMPLETE THE EMPLOYEE FATALITY AND SERIOUS INJURY REPORT AND CONTACT DEPARTMENT PERSONNEL & RISK MANAGEMENT. IF OUTSIDE OF BUSINESS HOURS YOU WILL NEED TO CONTACT CAL/OSHA IMMEDIATELY (NUMBER FOUND ON LINKED FORM).

INFECTIOUS DISEASE INCIDENTS SUCH AS COVID-19 EXPOSURE AND BLOODBORNE PATHOGEN EXPOSURES THROUGH NEEDLE STICKS: COMPLETE THE COMMUNICABLE DISEASE EXPOSURE REPORT AND SUBMIT TO RISK MANAGEMENT (MAY BE SUBMITTED WITH THIS FORM) AND YOUR DEPARTMENT EXPOSURE CONTROL OFFICER IMMEDIATELY.

SUPERVISOR'S INVESTIGATION REPORT CONTINUED ON PAGE 2

INJURY NARRATIVE:

PLEASE COMPLETE THE BELOW ITEMS DURING YOUR INVESTIGATION AFTER COMPLETING THE SECTIONS ABOVE, PROVIDING A THOROUGH INCIDENT INVESTIGATION WITHIN ONE BUSINESS DAY. IF MORE SPACE IS NEEDED, ATTACH ADDITIONAL PAGES.

A. DESCRIBE THE INJURY ALLEGED, INCLUDING HOW THE EMPLOYEE DESCRIBES WHAT OCCURRED, THE CONTRIBUTING CAUSES AND ROOT CAUSE OF THE INJURY YOU HAVE IDENTIFIED, AND DETAILS ABOUT THE LOCATION WHERE THE INJURY OCCURED.

Questions to address: What details did the employee provide you? What work task was the employee completing when the injury occurred? Was anyone else involved? What activities leading up to the injury and any potential contributing causes have you determined during the course of your investigation. What safety concerns are applicable to this report, including weather conditions if outside, faulty equipment, uneven terrain, limited space/congested hallways, etc.?

A.1. LIST INJURED BODY PART(S) ALLEGED:

Indicate the injured body part(s) and whether the injured body part(s) is/are on the left, right, or both sides of the body. Please be as specific as possible.

B. WITNESSES TO THE INCIDENT:

Are there witnesses of the injury/illness? YES ☐ NO ☐

Witness #1 Name:	Witness #1 Phone #:
Witness #2 Name:	Witness #2 Phone #:
Witness #3 Name:	Witness #3 Phone #:

REVIEW:

PLEASE COMPLETE THE BELOW ITEMS AT THE END OF YOUR INVESTIGATION AFTER COMPLETING THE SECTIONS ABOVE, PROVIDING YOUR ANALYSIS OF THE INCIDENT BELOW. IF MORE SPACE IS NEEDED, ATTACH ADDITIONAL PAGES.

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

Communicate to the employee potential preventative measures that should be followed to prevent this type of incident from happening again and indicate if there are any actions or repairs needed on part of the department in this section of the report to ensure any unsafe conditions are corrected.

D. PLEASE EXPLAIN YOUR REASONING WHETHER OR NOT YOU ARE QUESTIONING THE INJURY.

Do you have any reason to believe that this injury did not occur? Is there any additional evidence (security footage, witnesses to the incident, etc.) that supports the claims made by the employee?

Investigator's Name:		**Investigator's Phone Number:**
		[☐ Sign] Double click!
	Investigator's Signature	

E. DEPARTMENT HEAD'S CONCURRENCE/COMMENTS:

If you are questioning the injury, please explain the reasoning behind that assessment. Please list any corrective action being taken (request to repair any unsafe conditions, policy reminders, etc.).

Department Head's Name:		**Department Head's Phone Number:**
		[☐ Sign] Double click!
	Department Head's Signature	

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