

NC Department of Administration

Supervisor's Accident/Incident Investigation Report

The First Report of Injury is one of the forms you must fill out for any work related Injury, Illness, or Near Miss. This form along with the Worker's Compensation Form 19 is used for Worker's Compensation consideration. Return the completed and signed form to:

NC DEPT OF ADMINISTRATION HUMAN RESOURCES MGMT OFFICE
1322 MAIL CENTER, RALEIGH, NC 27699-1322
FAX 919 715-7669

Instructions: Print or type to complete all areas of this two-page form (you may complete the form electronically).

If something **DOES NOT APPLY**, enter "DNA".

Form will be returned if not completely filled out.

Information about the Employee

- 1) Full Name: _____
- 2) Job Title: _____
- 3) Division: _____
- 4) Home Address: _____
(Street, City, State, Zip County)
- 5) Phone: (Home) _____ (Work) _____
Area code Area code
- 6) Birth Date: _____ Age: _____ Male Female
- 7) Hire Date: _____ Full Time Part Time Temporary
- 8) Supervisor Name: _____ E-mail Address: _____
- 9) Supervisor Sig.: _____ Tel #: _____

Information about the Case

Did employee:

- See a doctor:
Complete this form and a Worker's Compensation Form 19.
- Receive First Aid:
Complete this form only.
- Have a Near Miss/Return to work.
Complete this form only.

- 1) Date of Injury/Illness/Near Miss: _____
(month/day/year)
- 2) Time employee began work: _____ a.m. p.m.
- 3) Time of event _____ a.m. p.m.

Information about the Physician or Other Health Care Professional

(Should seek care at an approved facility)

- 1) Name of treating physician or other health care professional: _____
- 2) 1) If treatment was given away from the worksite, where was it given
Facility: _____
Street: _____
City: _____

(Please complete back)

Information about the Incident

- 1) **Tell us where the incident occurred.** On state property Off state property
Be specific. Examples: Albemarle Bldg, Suite 1065; Mail Service Center; MFM, Parking lot.

- 2) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: “climbing a ladder while carrying roofing materials”; “spraying chlorine from a sprayer”, “daily computer key-entry”.

- 3) **What Happened?** Tell us how the injury occurred. Examples: “When ladder slipped on wet floor, employee fell 20 feet”; Employee was sprayed with chlorine when gasket broke during replacement”; Employee developed soreness in wrist while keying for prolong periods”.

- 4) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than “hurt,” “pain,” or “sore”. Example: “strained back”; “chemical burn”; carpal tunnel syndrome”; indicate what side: “sprained right hand”; dust in left eye”; “bruised right shoulder.”

- 5) **What object or substance directly harmed the employee?** Examples: “concrete floor”; “radial arm saw”. *If this question does not apply to the incident, leave blank.*

- 6) **Was employee in an emergency room?** Yes No

- 7) **Was employee hospitalized overnight as an in-patient?** Yes No

- 8) **Did employee have any lost or restricted days?** Yes No

How many lost days? _____ How many restricted days? _____

Notify the Safety Director / Worker’s Compensation Coordinator of any changes in loss or restricted days at (919) 807-2480

- 9) **Was employee provided and using PPE at the time of the incident?**

Additional comments provided by supervisor and employee: