

Information contained on this form is for official use only, for the exclusive benefit of the C 6 8 / %

ESTIGATION: TO BE COMPLETED BY SUPERVISOR

	PHONE/EXT	DATE REPORTED	TIME REPORTED
Location: <input type="checkbox"/> On-Site <input type="checkbox"/> Off-Site Overtime Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No Address and/or worksite description:		Injury / Illness / , Q F L	Body Part(s) Affected:

30H0DVH FKHFN ER[QH DUH \$ RUVW RQO\ QR SURSHUW\ GDPDJH RU ERGLO\ LQM XU

DESCRIBE SEQUENCE OF EVENTS (Specify activity, policy or procedure performed prior to incident. Use additional sheets as needed)

DID THE INJURY / ILLNESS OCCUR? (Please include any Safety Policy and Procedures that were not followed. Use additional sheets as needed):

REASON:  Yes  No 1RDWWDFKGDWHGDQGV LJQHGLWQHVV6WDWHPHQWIRUPSDJHWZRIWKLVRFXPHQW

CAUSE:  Yes  No @1R DWWDKGDWHGDQGV LJQHGLWQHVV6WDWHPHQWIRUPSDJHWZRIWKLVRFXPHQW

Was this injury/illness/ incident caused by unsafe work?  
[ ] Yes [ ] No  
DVVLJQHGXWLHV"

Was this injury/illness/ incident caused by unsafe work?  
[ ] Yes [ ] No (If yes, explain and attach photos)

R QRW ZLVK WR ILOH D :RUNHUV &RPSHQVDWLRQ &ODLP IRUP RU VHHN PHGLFDO  
ULJKW WR ILOH D FODLP 3HU /& DQ HPSOR\HH KDV \H DU IURP WKH GDWH R  
JP  
(PSOR\HH 6LJQDWXUH BB  
'DWH

Date/Time:

Department Manager Name Review and Approval: (print)	Signature:	Date/Time:
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**SUPERVISOR INJURY / ILLNESS INVESTIGATION REPORT**

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**WITNESS STATEMENT FORM**

**To be completed by incident witness:**

**Information about the person making this statement:** (Please print or write clearly.)

First name \_\_\_\_\_ Last name \_\_\_\_\_

Job title \_\_\_\_\_ Department \_\_\_\_\_ Division \_\_\_\_\_

Department Manager \_\_\_\_\_ Department Supervisor \_\_\_\_\_

**Describe exactly what you observed, regarding this incident.** (Use additional sheets if needed)

Date of Injury / Illness \_\_\_\_\_ Time of incident \_\_\_\_\_ AM / PM

Location of incident \_\_\_\_\_

Other witnesses \_\_\_\_\_

Statement \_\_\_\_\_

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<p>_____</p> <p><b>Witness signature</b></p>	<p>_____</p> <p><b>Date/Time</b></p>
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**Box below to be completed by Dept./Div. representative:**

Statement received by (print name and signature) _____
Date/time statement received _____