



Nevada System of Higher Education Supervisor's Incident Investigation Form

Institution		Address _____		
Department _____		Location of Incident _____		
1. Employee Name _____	2. Sex	3. Age	4. Date of Incident _____	5. Time of Incident _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
6. Job Title _____	7. Length of Employment <input type="checkbox"/> Less than 1 mo. <input type="checkbox"/> 6 mos. – 1 yr. <input type="checkbox"/> 1-5 yrs. <input type="checkbox"/> More than 5 yrs.		8. Length of Time in Position <input type="checkbox"/> Less than 1 mo. <input type="checkbox"/> 6 mos. – 1 yr. <input type="checkbox"/> 1-5 yrs. <input type="checkbox"/> More than 5 yrs.	
9. Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary <input type="checkbox"/> Volunteer	10. Was the employee performing duties within their job scope? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____ _____		11. Has the employee received training related to this incident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list date of most recent training: ____/____/____ Topic: _____ Training Provider: _____	
12. Physical demand of position: <input type="checkbox"/> Very heavy work <input type="checkbox"/> Heavy Work <input type="checkbox"/> Medium Work <input type="checkbox"/> Light Work <input type="checkbox"/> Sedentary Work				
13. Who was the injury first reported to? _____	14. Date Reported ____/____/____		15. Was a C1 Notice of Injury form completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Injured Body Part: (check all that apply) <input type="checkbox"/> Head, face <input type="checkbox"/> Eye <input type="checkbox"/> Neck, shoulder <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Back <input type="checkbox"/> Rib <input type="checkbox"/> Hernia, rupture <input type="checkbox"/> Arm, elbow <input type="checkbox"/> Hip <input type="checkbox"/> Leg, knee <input type="checkbox"/> Foot, ankle <input type="checkbox"/> Thumb/finger <input type="checkbox"/> Chest, lower trunk <input type="checkbox"/> Toe <input type="checkbox"/> Wrist/hand <input type="checkbox"/> Heart <input type="checkbox"/> Lungs <input type="checkbox"/> Mouth <input type="checkbox"/> Other _____				
17. Injury Type: (check all that apply) <input type="checkbox"/> Burn <input type="checkbox"/> Sprain, strain <input type="checkbox"/> Fracture <input type="checkbox"/> Bruise, abrasion <input type="checkbox"/> Cut, puncture, or laceration <input type="checkbox"/> Amputation <input type="checkbox"/> Concussion <input type="checkbox"/> Crush, mash <input type="checkbox"/> Syncope/fainting <input type="checkbox"/> Death <input type="checkbox"/> Other _____				
18. Severity of Injury: (check all that apply) <input type="checkbox"/> No action/treatment needed <input type="checkbox"/> Restricted Duty <input type="checkbox"/> Lost time from work <input type="checkbox"/> First Aid <input type="checkbox"/> Dr. Visit <input type="checkbox"/> Urgent Care <input type="checkbox"/> Emergency Room <input type="checkbox"/> Fatality <input type="checkbox"/> Other _____				

19. Briefly describe how the incident occurred:

20. Incident sequence. Describe in reverse order the occurrence of event preceding the injury and accident. Start with the injury and moving backward in time, reconstruct the sequence of events that led to the injury.

- A. **Injury event** _____
- B. **Incident event** _____
- C. **Preceding event #1** _____
- D. **Preceding event #2, 3, etc.** _____

21. Causal factors. Causal factors are events and conditions that contributed to the incident. Check all that apply.

Environmental

- Icy/snowy conditions
- Heat
- Cold
- Noise
- Smoke/fumes
- Dust
- Other _____

Work Conditions

- Defective equipment/tools
- Poor housekeep/clutter
- Poor walking surface
- Inadequate protective equipment
- Inadequate lighting/poor visibility
- Inadequate ventilation
- Other _____

Personal Factors

- Unsafe act
- Lack of knowledge/skill
- Outside of job duties
- Inadequate planning
- Fatigue/stress
- Not wearing personal protective equipment/improper footwear
- Deviation from procedure
- Violation of safety rule
- Inattention/distraction
- Other _____

Job Factors

- Poor work area set up
- Inadequate equipment/tools
- Inadequate workspace
- Lack of rules/procedures
- Maintenance issues
- Inadequate inspections
- Inadequate resources
- Other _____

Ergonomic Factors

- Awkward posture
- Static posture
- Repetitive motion
- Forceful motion
- Bending/twisting motion
- Overhead work
- Other _____

Management Issues

- Insufficient planning
- Budgetary constraints
- Insufficient training
- Safety issue not prioritized
- Insufficient enforcement of rules
- Understaffed
- Other _____

<p>22. Causal Factors: Section 2 (Complete only for slips/trips/falls) *Please include a photograph of the specific location and anything that may have caused the slip/trip/fall. Was there a specific hazard that may have caused the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ Did the employee's footwear contribute to the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the location in the employee's immediate work areas? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often does the employee walk through the area on an average day? _____ Is this location publicly accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>23. Corrective action plan. Please list all corrective actions that have been, or will be, taken to prevent this incident from occurring again. Please include how all casual factors identified above will be addressed.</p> <p>A. Immediate action: _____ _____ _____</p> <p>B. Short term plan: _____ _____ _____</p> <p>C. Long term plan: _____ _____ _____</p>			<p>Implementation Date(s):</p>
<p>24. Witnesses. Please list full name and contact information. Witness #1 _____ Witness #2 _____ Witness #3 _____</p>			
<p>25. Describe any damage to property or equipment. If the incident involved an NSHE vehicle, please include the vehicle make/model/EX plate number.</p> <p>_____</p> <p>_____</p>			
<p>26. Additional Information:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>			
27. Investigating Supervisor	Phone	Signature	Date

Please submit form to the NSHE Risk Management Office at risk@nshe.nevada.edu.