

CHAPTER 7

THE DEPARTMENT SUPERVISORS

RESPONSIBILITIES

DEPARTMENT SUPERVISORS

1. Are responsible for encouraging the proper attitudes toward safety job performance in themselves and in their subordinates.
2. Shall train employees in job safety and health practices and complete a training record or copy of which shall be forwarded to the Department. Safety Representative for record keeping.
3. Shall investigate promptly and thoroughly every accident to determine its cause and to prevent any recurrence; report it to the County Safety Officer or his designee at the earliest possible time. (See Supervisor's Incident Report Page 3).
4. Shall require all employees to comply with the Occupational Safety and Health Standards and all rules, regulations, and orders applicable to his/her own actions and conduct.
5. Shall set the example of appropriate safety behavior for which employees can follow.
6. Shall allow employees to report health and safety concerns without fear of reprisal.
7. Shall implement departmental self-inspection guidelines for:
 - a. Initial inspections
 - b. Frequency of inspections.

Supervisor
Complete

SHASTA COUNTY RISK MANAGEMENT

SUPERVISOR'S INCIDENT REPORT

EMPLOYEE NAME:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME
JOB TITLE:	DEPARTMENT:	

INVESTIGATION

*Interview the Employee and investigate the reported incident and then complete the following:
Use the back of this form and additional sheets as necessary to obtain and record all pertinent information*

Check this box if a Declination of Medical Treatment Packet was previously completed for this same incident.

INCIDENT DATE:	TIME OF INCIDENT:	LOCATION OF INCIDENT (building location, department, etc.):
DATE REPORTED:	TIME BEGAN WORK:	

DESCRIPTION OF INCIDENT - Interview the Employee and any witnesses, and determine how the incident occurred and what the employee was doing prior to incident.

Has a similar incident occurred in the past? Yes NO Have you contacted Fleet Facilities

DESCRIPTION OF THE INJURY- Body part injured, type of injury, etc.

INJURY SOURCE- Investigate and comment on the source of the injury. For example, if the employee has a laceration caused by a tool, examine the tool and indicate whether it appears to be in proper condition, is properly guarded, etc.

HOW INJURY OCCURRED - Investigate how the injury occurred, and determine whether it was caused by an unsafe act or an unsafe condition, or both. Use the sections below to detail the nature of the act(s) or condition(s) that may have caused or contributed to the incident.

UNSAFE ACT (IF ANY)	PREVENTIVE ACTION(S) TO BE TAKEN
<input type="checkbox"/> IMPROPER BODY POSITIONING <input type="checkbox"/> HURRIED OR DISTRACTED WORK <input type="checkbox"/> FAILURE TO USE PROPER PERSONAL PROTECTIVE EQUIPMENT (Specify): <input type="checkbox"/> NO UNSAFE ACT	<input type="checkbox"/> PROVIDE ADDITIONAL TRAINING <input type="checkbox"/> DISCIPLINE EMPLOYEE <input type="checkbox"/> MODIFY/DISCONTINUE WORK PRACTICE <input type="checkbox"/> OTHER:
<input type="checkbox"/> UNSAFE WORK METHOD <input type="checkbox"/> UNSAFE USE OF EQUIPMENT <input type="checkbox"/> IMPROPER LIFTING TECHNIQUE <input type="checkbox"/> OVEREXERTION <input type="checkbox"/> OTHER:	
UNSAFE CONDITION (IF ANY)	PREVENTIVE ACTION(S) TO BE TAKEN
<input type="checkbox"/> DEFECTIVE EQUIPMENT <input type="checkbox"/> UNGUARDED EQUIPMENT <input type="checkbox"/> TRIP/SLIP HAZARD ON FLOOR <input type="checkbox"/> UNSAFE ARRANGEMENT OF ITEMS <input type="checkbox"/> IMPROPER DRESS OR APPAREL	<input type="checkbox"/> ELIMINATE CONDITION <input type="checkbox"/> REPAIR CONDITION <input type="checkbox"/> REPORT CONDITION TO: <input type="checkbox"/> OTHER:
<input type="checkbox"/> IMPROPER LIGHTING <input type="checkbox"/> INADEQUATE VENTILATION <input type="checkbox"/> UNFORESEEN HAZARD/WEATHER <input type="checkbox"/> OTHER: <input type="checkbox"/> NO UNSAFE CONDITION	

LOST-TIME CERTIFICATION FROM SUPERVISOR

Did employee lose at least one day of work after injury? Yes NO Did employee receive full wages for last day worked? * Yes NO

If "Yes" Last day worked: _____ Date claim form provided to employee _____

Has employee returned to work? Yes NO Name of clinic, physician, or hospital: _____

Date employee returned to work: _____ * Indicate if sick leave was used: Yes NO

What safety training did the employee receive in the past 12 months that is specifically related to this incident?

What type of safety training will be necessary?

SUPERVISORY SIGNATURES

SUPERVISOR (Print Name):	TITLE	DEPARTMENT HEAD (OR DELEGATE)	
SIGNATURE:	DATE	SIGNATURE	DATE
TELEPHONE:			

WITNESS STATEMENT

If there was a witness to this incident, they should attach a detailed statement regarding their observation of the incident, and sign below.

WITNESS STATEMENT (use back of page if necessary):

NAME:	SIGNATURE:	DATE:
-------	------------	-------

Within 7 days of receiving information that a recordable work-related injury or illness has occurred, this form must be completed.