Ensure Highlight Fields, found in the top right corner, has been selected. Data fields will be highlighted when this feature is enabled. Click to check a box or enter data in a field; use the Tab key to move to the next field.

University of Wisconsin
Office of Human Resources
21 N Park Street, Suite 5101
MADISON, WI 53715
UWS/OSLP-2 (9/07)

Supervisor and Safety Coordinator Investigation Report for Injury or Illness

WC Claim Number

Employee Name (as it appears on payroll)	Employee Job Title:	Social Security Number	The occurrence was an: ☐ Injury ☐ Illness

Supervisor's Instructions (Direct any questions to your Facility Safety Coordinator or Agency's Safety Manager)
1. Sign and date the report and immediately submit within 24 hours to your Agency's Worker's Compensation Coordinator.
2. Forward a copy of the report to your Agency or Facility Safety Coordinator.

What sources of information were used to analyze this injury/illness? **Check all that apply.**
☐ Interviewed affected employee(s) ☐ Interviewed witnesses ☐ Examined scene
☐ Reviewed records ☐ Analyzed evidence ☐ Other (explain)

Date paperwork received from employee (mm/dd/yyyy)

Please describe what the employee was doing when the injury/illness occurred.

Do you agree with the employee's account of the injury or illness? ☐ Yes ☐ No If no, please explain.

What corrective action has been taken? What corrective action is planned for the future? When do you plan to complete the corrective action?

In your opinion, what can be done to prevent a similar occurrence?

For **Repetitive task injuries**: What specific activities does the employee perform with his/her wrists, hands, arms, knees, shoulders, and/or neck?
How often is the task performed? How many hours per day? How many days a week?

If **Material handling** was involved, describe the object/person being handled/lifted at time of the injury/illness.
Approximate size: Approximate weight:
Description:

If **Operating equipment, machinery and/or other motorized equipment/s** lead to injury or illness, describe the equipment/s:

Was this equipment being properly used? ☐ Yes ☐ No ☐ Don't know If no, please explain:

Was there any other equipment/resource available to the employee but not used?

Explain, the **environmental factors** (lighting, temperature, noise, vibration, dust, or weather), if any, that contributed to this injury or illness?

Supervisor's Name (please print):	Title:	Date: (mm/dd/yyyy)
Report prepared by (Supervisor's name):		Phone Number:

Safety Coordinator's Instructions
1. Complete this section of the report. 2. Sign and date the completed report and send to Agency WC Coordinator within 48 hours

Is there follow up to ensure corrective actions are completed? ☐ Yes ☐ No, Who is responsible for follow up?

Have corrective actions been implemented? ☐ Yes ☐ No, How much time is needed to implement them?

Corrective action will be communicated to: ☐ Management ☐ Supervisors ☐ Affected employee(s) ☐ Other agency employees

Would corrective action apply to other areas of the operation or agency? ☐ Yes ☐ No
Please explain:

Safety Coordinator's Name:	Date:	Phone Number

The social security number must be provided for the use of positive identification in the processing of any claims.