CITY OF SAINT PAUL

SUPERVISOR'S SAFETY REPORT **INJURY OR AGGRAVATION**

THIS FORM MUST BE COMPLETED by the supervisor for each work-related injury or aggravation within 24 hours

Date of hire: _____ Time employee started work _____ COSP Employee Number _____

DEPARTMENT _____ **DIVISION** _____ **ACTIVITY CODE**_____

1. First Name _____ Middle Name or Initial _____ Last Name _____
2. Date of Injury _____Time of Injury _____
3. Type of Claim ☐ No Injury/Illness ☐ First Aid Treatment Only ☐ Injury ☐ Illness
4. Attachments ☐ Photos ☐ Diagrams ☐ Statements ☐ Supporting Documents
5. Type of Incident:
   - ☐ Assault/Violent Act by Person
   - ☐ Caught in Equipment or Object
   - ☐ Fire/Explosion
   - ☐ Overexertion/Sprain/Strain
   - ☐ Other (Explain) _____
   - ☐ Slip/Fall
   - ☐ Struck Against Object
   - ☐ Struck by Object
   - ☐ Transportation Accident
   - ☐ Repetitive Motion
   - ☐ Electrical Exposure
   - ☐ Exposure to Harmful Substance
   - ☐ Patient Lifting
6. Location of incident _____
7. Was incident on city property? ☐ Yes ☐ No
8. Was site of injury visited? ☐ Yes ☐ No Date of site visit _____
9. Contributing Work Activity or Procedure:
   - ☐ Operating without authority
   - ☐ Failure to make secure/shutdown
   - ☐ Working/moving at unsafe speed
   - ☐ Failure to warn/signal
   - ☐ Failure to cleanup/pickup
   - ☐ Nullifying safety devices
   - ☐ Using equipment unsafely
   - ☐ Using unsafe equipment
   - ☐ Taking unsafe position/posture
   - ☐ Failure to ask for assistance
   - ☐ Failed to follow rules/procedures
   - ☐ Taking shortcuts
   - ☐ Horseplay
   - ☐ Failure to use PPE available
   - ☐ Other (Explain) _____
10. Root Cause(s) of Incident: (events leading to the incident)_____
    _____
    _____
11. What can be done to prevent similar occurrence? _____
    _____
12. Did another person, tools, or equipment contribute to this injury? ☐ No ☐ Yes- -Identify and describe how _____
    _____
    _____
13. If injury occurred outdoors, describe the weather conditions _____
    _____
14. Environmental Conditions:
    - ☐ Inadequate Guards or Safety Devices
    - ☐ Inadequate Warning Devices
    - ☐ Fire/Explosion Hazards
    - ☐ Unexpected Movement Hazards
    - ☐ Weather Related
    - ☐ Poor Housekeeping
    - ☐ Projection Hazards
    - ☐ Congestion, Close Clearance
    - ☐ Hazardous Placement/Storage
    - ☐ Hazardous Personal Attire
    - ☐ Defective Equipment, Tools, Etc.
    - ☐ Hazardous Chemical Conditions
    - ☐ Noise
    - ☐ Inadequate Illumination
    - ☐ Other (Explain)_____
15. Was or can any corrective action taken? ☐ No ☐ Yes—Describe_____
    _____
    _____
    _____
16. Any additional information regarding the case _____
    _____
    _____

Supervisor's Name (Print) _____ Supervisor's Phone _____

Supervisor's Signature _____ Date _____

DEPT AND SPVRS SHOULD KEEP A COPY OF THE COMPLETED FORMS BEFORE SENDING THEM TO WORKERS COMPENSATION

DEPARTMENT VIA FAX: 651/266-8886 OR EMAIL: WorkersCompensation@ci.stpaul.mn.us