

"INJURY & ILLNESS"

Injury & Illness Investigation Report

Instructions

- Report all work-related injuries or illnesses no matter how minor to your supervisor / manager. Use First Aid Log to document minor injuries such as splinters, small scrapes and cuts. All other injuries or illnesses will be documented below.
- Section 1 is to be completed by employees / person reporting injury or illness as soon as possible and submitted to your supervisor / manager for further action.
- Section 2 is to be completed by direct supervisor / manager or safety director.
- Section 3 is to be completed by the sites designated authority.

Section 1 – Person injured or reporting illness to fill in this section - Please provide all details regarding your injury or illness below

Your full name: _____ I am reporting a work related: injury illness Injury/illness date: _____ Time of injury/illness: AM PM

Have you informed a supervisor / manager of this injury/illness? yes no Name of supervisor / manager: _____ Date injury/illness reported: _____ Time reported: AM PM

Employee Male Non-employee Female Phone #: _____ Location injury/illness occurred: _____ Company premises: yes no

Current job title: _____ Assigned department: _____ Employee status: Full time Part time Seasonal Temporary

Name of witness(es) and location of each witness during the injury / illness: _____

Where, exactly, did the injury / illness occur (specific within a department or area of facility): _____

What were you doing at the time of the injury / illness? _____

Describe step by step what led up to the injury / illness (continue the back of page if necessary): _____

How do you think the injury / illness could have been prevented? _____

Describe the injury / illness: _____

For injuries, indicate the location by circling below:

Page One

Section One

The employee should fill out all fields in section one completely and obtain all signatures.

Section One is both Page One and Page Two.

Did you see a doctor about this injury / illness? yes no If yes, whom did you see? _____ Doctor's phone number: _____

Date: _____ Time: _____ For injury, has this part of your body been injured before? yes no If yes, when? _____

What equipment, tools were being used at the time of the injury / illness? _____

Indicate PPE in use during the injury / illness:

Eye Protection Hearing protection Gloves Safety Footwear Apron Respirator Dust Mask Safety Helmet High Visibility Clothing Safety Harness Face Shield Welding Helmet Other (list additional PPE): _____

I have answered the above questions truthfully to the best of my knowledge. I also understand that the Company will make every effort to provide alternative work if restrictions are issued by the treating physician.

Your signature: _____ Date: _____ Supervisor: _____ Date: _____

Medical Treatment Declination Statement

I have been offered medical treatment and have declined it at this time; however, I understand that I may seek medical treatment at a later date. I also understand that I must report to my supervisor / manager in the event that I do seek medical treatment.

Employee signature: _____ Date: _____ Witness signature: _____ Date: _____

Medical Record Release

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, or other medically related facility, insurance administrator, government organization, employer, and any of their agents performing services relating to any employee benefits or workers' compensation, other organization, institution, or person who has any records or knowledge of me or my health (including any disorder of the immune system, use of drugs or alcohol, mental disorders, physical history, condition, advice, or treatment) to release this information to Universal Forest Products, its subsidiaries, or their duly authorized representatives. I understand that in executing this authorization, information obtained by the Company will be used for verifying, evaluating, and administering a claim for benefits and is valid only for the duration of my claim. I know that I or my authorized representative have a right to request a copy of this authorization, and a copy shall be as valid as the original.

Employee name (print): _____ Employee signature: _____ Date: _____

Page Two

Continue to Page Three...

PROWOOD™

"INJURY & ILLNESS"

Section Two

A supervisor, manager, or safety coordinator must complete section two in it's entirely.

Section 2 – Supervisor, manager or safety director to fill in this section - Please provide <i>Investigative details below</i>			
Employees hire date:	Medical treatment: <input type="checkbox"/> First Aid on-site <input type="checkbox"/> Doctor, Clinic, Hospital <input type="checkbox"/> Medical Declined <input type="checkbox"/> Emergency Responders		
Were there any safety standards that were compromised that led to the incident? <input type="checkbox"/> yes <input type="checkbox"/> no if yes, please describe:			
Describe any damage to equipment or premises due to the incident:			
List any factors that you believe contributed to the incident:			
How severe was the accident and how often could it happen if corrections / improvements are not made? Severity potential: <input type="checkbox"/> Major <input type="checkbox"/> Serious <input type="checkbox"/> Minor Frequency potential: <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Seldom			
What do you think could be done differently to prevent reoccurrence:			
Completed by:	Title:	Date:	Phone:
Names of investigation team members:		Reference applicable attachments: Written witness statements? <input type="checkbox"/> yes <input type="checkbox"/> no List of light duty assignments reviewed? <input type="checkbox"/> yes <input type="checkbox"/> no Photographs / Videos? <input type="checkbox"/> yes <input type="checkbox"/> no Maps / drawings? <input type="checkbox"/> yes <input type="checkbox"/> no Workers Compensation survey? <input type="checkbox"/> yes <input type="checkbox"/> no	
Section 3 – Post review section - Please conduct a final review of all investigative findings, conclusions and corrective actions.			
a) Verify investigative efforts are complete. b) All applicable reference documents and articles are reviewed and accessible. c) All recommended corrective actions are complete / verified.			
Post review sign-off by:	Title:	Date:	Phone:

Section Three

The plant manager usually completes section three after the investigation.