

## Supervisors Incident Analysis Report

STATE OF NEBRASKA INCIDENT INFORMATION

This form is used by HR Shared Services to assist in the investigation of the Workers' Compensation Claim and to determine root cause to prevent similar incidents. Please include as much detail as possible.

Agency: \_\_\_\_\_ Division: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

Who Incident was Reported to: \_\_\_\_\_

**INDIVIDUAL INVOLVED (ATTACH ADDITIONAL REPORTS IF MORE THAN ONE PERSON WAS INVOLVED)**

Name of Person Injury/Involved: \_\_\_\_\_ Male  Female

**DESCRIPTION OF ACCIDENT/ INCIDENT/INJURY/ILLNESS (CHECK ALL THAT APPLY)**

**Type of Incident:**

Minor Injury of Illness       Serious Injury or Illness       Fatality       Other

Incident Location: \_\_\_\_\_

Date of Incident: \_\_\_\_\_ Time of Incident \_\_\_\_\_ AM  PM

**Property Damage:**

Yes  No  Property Involved: \_\_\_\_\_

Vehicle Involved: Yes  No  Vehicle Driver: \_\_\_\_\_

License Plate Number: \_\_\_\_\_ Vehicle Make & Model: \_\_\_\_\_

Type of Activity during which Incident/Injury occurred: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

First Aid Treatment/Immediate Remedy: \_\_\_\_\_

What do you believe the root cause(s) of the event to be? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How could this have been prevented? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_