

# NCSU Supervisor's First Report of Incident

The Supervisor must complete this form for any work related Injury, Illness, First-Aid, or Near-Miss incident.

Instructions: **All sections of this form must be completed and signed by the Supervisor**

- ✓ Print or Type to complete all sections of the form. You may also complete the form online.
- ✓ If a question does not apply, enter "NA" or "Not Applicable"
- ✓ Return the completed and signed forms to BOTH:
  - o **Workers' Comp**  
Email: [WorkersComp@ncsu.edu](mailto:WorkersComp@ncsu.edu)  
-or- Campus Box 7215  
-or- fax: 888-317-2890

**AND**

- o **Environmental Health & Safety**  
Email: [AccidentReport@ncsu.edu](mailto:AccidentReport@ncsu.edu)  
- or- Occupational Safety, Campus Box 8007,  
- or- fax 919-515-6307

In addition to this form, Supervisors reporting employee injuries must also submit

- ✓ [Supervisor's Medical Treatment Authorization Form](#)
- ✓ [Employee's Statement Form](#)
- ✓ [Employee's Use of Leave Options Form](#)

Forms are available at

<https://ehs.ncsu.edu/accident-reporting/> and  
<https://benefits.hr.ncsu.edu/workers-compensation/>

Refer to the [Incident Report Forms Flowchart](#) for forms assistance.

## SECTION I

### Information About the Employee

- 1) Full Name: \_\_\_\_\_
- 2) Job Title: \_\_\_\_\_  EHRA  SHRA  Temporary
- 3) Division/ College: \_\_\_\_\_ Department \_\_\_\_\_
- 4) Employee Identification Number: \_\_\_\_\_ *This number is found on the front of employee's University ID badge.*
- 5) Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_
- 6) Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_
- 7) Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female
- 8) Hire Date: \_\_\_\_\_  Full Time (Regular)  Part Time  Temporary
- 9) Supervisor's Name: \_\_\_\_\_ Personnel Representative: \_\_\_\_\_  
Supervisor's Phone Number: \_\_\_\_\_ Representative's Phone Number: \_\_\_\_\_  
Supervisor's Email: \_\_\_\_\_ Representative's Email: \_\_\_\_\_

**SECTION II**

**Information About the Incident**

**10) Did the employee:**

- See a doctor, nurse, or nurse practitioner - includes Student Health Center
- Receive First Aid.....  at work or  at a medical facility
- Experience a Near-Miss..... (Returned to work with no injury or treatment)

11) Date of Incident: \_\_\_\_\_ Time of incident: \_\_\_\_\_  AM  PM  time cannot be determined

12) Date Supervisor informed of Incident: \_\_\_\_\_ (mm/dd/yyyy)

13) Time employee began work: \_\_\_\_\_  AM  PM

14) Did the employee lose consciousness?.....  Yes  No (If Yes, Call 919-515-3000, leave message.)

15) Was employee treated in an emergency room?.....  Yes  No (If Yes, Call 919-515-3000, leave message.)

16) Was employee hospitalized overnight as an in-patient?...  Yes  No (If Yes, Call 919-515-3000, leave message.)

17) Was any body part amputated (including a fingertip)?.....  Yes  No (If Yes, Call 919-515-3000, leave message.)

18) Did the employee lose an eye?.....  Yes  No (If Yes, Call 919-515-3000, leave message.)

19) Did the incident involve exposure to infectious agents, human blood, or recombinant or synthetic nucleic acid molecules?.....  Yes  No (If Yes, Call 919-515-3000, leave message.)

20) If the incident involved a mammal bite, had the animal been vaccinated for rabies?.....  Yes  No  Unknown  
If No, has a rabies test been initiated?...  Yes  No  Unknown

21) Did the incident involve a chemical or radiological exposure?  Yes  No

If Yes, list chemicals/products \_\_\_\_\_

22) **Tell us where the incident occurred.** Campus Building: \_\_\_\_\_ Room No.: \_\_\_\_\_

*If not a campus building or room, then be specific about location. Examples: (Administrative Services parking lot, Field lab name and location, Highway or Intersection, street address. Include City, County, and State.)*

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

City/Town: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

**23) What happened?**

*Tell us how the injury or illness occurred. Examples: "When ladder slipped on wet floor, employee fell 4 feet," "Grate slipped out of place when stepped on," "Employee developed wrist soreness over time," "Employee slipped on ice," "Employee tripped on step."*

**24) What was the employee doing just before the incident occurred?**

*Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials," "spraying cleaner from a hand sprayer," "daily computer entry," "walking down stairs."*

**25) What was the injury or illness?**

*Tell us the part of the body that was affected and how it was affected. Don't use "hurt, pain, sore..." Indicate side of the body. Examples: "strained lower left back," "chemical burn to right wrist," "Left hand and arm repetitive strain," "burned right palm"*

**26) What object or substance directly harmed the employee?**

*Examples: "concrete floor," "computer keyboard," "cleaning chemical," "radial arm saw," "vehicle component," "ice or snow"*

**SECTION III**

**Information About the Medical Professional, Treatment Provided, and Work Restrictions**  
*(Include a copy of the completed [Supervisor's Medical Treatment Authorization form](#))*

27) Name of treating physician or health care provider:

28) If treatment was given by a medical provider, where was it given?

Hospital or Clinic Name \_\_\_\_\_

Street \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Medical Provider's Phone Number: \_\_\_\_\_

29) Did the physician or medical professional direct the employee to stay home from work, due to the injury, after the date of injury?  Yes  No  Too early to determine

What date was the employee directed to return to work, if given \_\_\_\_\_(MM/DD/YYYY)

What date was the employee directed to have a follow up medical visit, if directed \_\_\_\_\_(MM/DD/YYYY)

30) Did the physician or medical professional direct the employee to restrict his or her work activities after the date of injury  Yes  No  Too early to determine

31) What restrictions did the medical professional direct?  
*(Examples: Limit lifting more than 20 lbs, no reaching with right arm, frequent breaks, no squatting or climbing, etc.)*

Is the unit able to accommodate the restrictions? \_\_\_ YES, the employee can work with the prescribed restrictions  
\_\_\_ NO, there is no work available and the employee must use leave

32) Describe the routine job functions (activities done at least once a week) affected by the work restriction(s).  
*(Examples: "Employee routinely lifts packages and equipment heavier than 20, lbs." "Employee must type with one hand." "Employee's job involves walking most of the time." "Employee does not routinely squat or climb.")*

What date was the employee directed to return to unrestricted work, if given: \_\_\_\_\_(MM/DD/YYYY)

What date was the employee directed to have a follow up medical visit, if directed \_\_\_\_\_(MM/DD/YYYY)

**Notify the Leave Administration Unit at 919-513-0106 if there is any medical treatment or any lost or restricted days as soon as possible. Leave Administration must receive notice within 24 hours after the injury.**

**SECTION IV**

**Supervisor's Incident Investigation**

The Supervisor shall investigate to determine the causes of the incident and to develop a corrective action plan. For assistance, contact: EHS 919-515-7915, [Accidentreport@ncsu.edu](mailto:Accidentreport@ncsu.edu),

33) **Contributing Factors:** Describe the events or conditions that contributed to the incident. *Examples: used improper equipment, inadequate training, inadequate procedure, equipment in poor condition, ice on steps, guard removed, bricks missing, chemical splashed in face, no Personal Protective Equipment (PPE), not covered in PM, object too heavy, poor housekeeping, rushing to complete task. Avoid generic statements like "not paying attention" or "not aware of surroundings." List several factors.*

34) **Causes:** Describe how the factors led to the incident. *Examples: Rushing to complete task and lifted too much weight causing back strain; water on floor leading to slip/fall; employee not properly trained on the task; ice cleats left in truck so employee had to walk to truck without them. List several causes.*

35) **Actions Taken and Preventative Measures to Prevent a Similar Incident:** *Actions to be taken such as improved or additional engineering controls, purchasing controls, training, work procedures. Look for system, equipment and people issues. Select issues early in the process. Select actions that will affect as many people as possible. Find multiple ways to address the causes. Examples: remove wheeled chairs from break area, install raised matting on wet floor areas, switch to less corrosive chemical, train all employees on proper lifting, provide extra ice cleats for office and service vehicle, put sand buckets near main entrance prior to ice events, provide extra event staffing so employees don't rushing through tasks.*

36) **Additional Comments:**

*I have read this report and I have accurately reported the information obtained from the investigation performed at this time. Should I receive additional information I will notify EH&S and Leave Administration.*

Supervisor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_