State of Wisconsin
University of Wisconsin System

FOR AGENCY USE ONLY
Claim Number:

SUPERVISOR'S INCIDENT ANALYSIS AND PREVENTION REPORT

INSTRUCTIONS:
1. **Within 24 hours of notice of the incident**, **complete this report based on your discussion with the employee.**
2. **Send report to your Worker's Compensation Coordinator.**

*** Indicates required information**

Employee Name	Date of Incident	Time of Incident	Date First Reported
Department Name and Location	Job Title	***Employee's Usual Work Schedule at Time of Incident:**	
		Start time: ☐ AM ☐ PM	**End time:** ☐ AM ☐ PM
		Hours per week:	**Days Per week:**

INCIDENT DESCRIPTION:
Describe the incident based on your investigation. Please include:

1. ***How did the injury/incident occur? Why?**

2. ***Where did it occur?**

3. Who was involved?

4. Who did you interview?

5. If equipment was involved, was it defective**?** ☐ Yes ☐ No If YES, please explain.

6. Describe any objects being handled at the time of incident, including size and weight.

Do you agree with the employee's account of the incident**?** ☐ Yes ☐ No If NO, Please explain.

Were safety procedures followed? ☐ Yes ☐ No **Was this activity part of their normal work duties?** ☐ Yes ☐ No

What corrective action should be taken to prevent a similar injury/incident?

Has the employee ever reported any physical condition(s) related to work or non-work activities (e.g. second job, participation in sports, home projects, etc.) that could be contributing to or aggravated by this injury / illness**?** ☐ Yes ☐ No If YES, please explain.

Additional Comments:

Supervisor's Name	Date
Title	Phone # ( )