

STATE OF HAWAII - SUPERVISOR'S ACCIDENT REPORT

PART A: ACCIDENT REPORT

				1. Date ____/____/____																																		
2. Employee's Name (Last, First, M.I.)			3. Social Security #		4. Age																																	
					5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female																																	
6. Department-Unit Name		7. Employee's Title:		8. Years in Position ____	9. Location of Accident																																	
10. On State Property? <input type="checkbox"/> Yes <input type="checkbox"/> No		11. Date of Injury/Illness ____/____/____		12. Accident Time ____ AM ____ PM																																		
				13. Date Disability Began ____/____/____																																		
				14. Date Reported ____/____/____																																		
15. Weather Condition: <input type="checkbox"/> Sunny <input type="checkbox"/> Rainy <input type="checkbox"/> Windy <input type="checkbox"/> Other _____			16. Appt. Type: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Other Appointment Termination Date: _____																																			
17. Name of Treating Physician			18. Address and Telephone Number of Treating Physician																																			
19. Describe the events that resulted in injury/illness. (What was employee doing and how did he/she get hurt?)				20. Indicate the type of personal protective equipment issued to the employee and if used at the time of the accident.																																		
21. Identify tools, equipment or materials the employee was using.				<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Issued</th> <th style="text-align: center;">Used</th> </tr> </thead> <tbody> <tr> <td>Head</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Eye/Face</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Body</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Hand - Arm</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Foot-Leg</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Respiratory</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Ear</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td colspan="3">State type of protection</td> </tr> <tr> <td colspan="3">_____</td> </tr> <tr> <td colspan="3">_____</td> </tr> </tbody> </table>			Issued	Used	Head	<input type="radio"/>	<input type="radio"/>	Eye/Face	<input type="radio"/>	<input type="radio"/>	Body	<input type="radio"/>	<input type="radio"/>	Hand - Arm	<input type="radio"/>	<input type="radio"/>	Foot-Leg	<input type="radio"/>	<input type="radio"/>	Respiratory	<input type="radio"/>	<input type="radio"/>	Ear	<input type="radio"/>	<input type="radio"/>	State type of protection			_____			_____		
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22. Describe in detail the nature of injury/illness and the part of body affected. (Use medical report, if available.)																																						
23. List the names and telephone numbers of witnesses (Use witness statement form).																																						
24. Has employee ever had a similar injury/illness? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, give date(s):																																						
25. What is the cause of the accident? <input type="checkbox"/> Unsafe Acts(s) <input type="checkbox"/> Unsafe Condition(s) <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Defective Equipment/Tools/Hardware <input type="checkbox"/> Management Inaction <input type="checkbox"/> Other _____ Describe the situation. See example on bottom backside of sheet. If equipment or motor vehicle, provide identification number.																																						
26. Explain how the accident (injury/illness) could have been prevented. "Be more careful" is not an acceptable response because it does not lead to prevention. Responses that lead to prevention include: replace broken chair, supervisor to attend safety management training, train employees on use of equipment, back safety, etc.																																						
27. _____ Immediate Supervisor's Name (Print)		_____ Supervisor's Signature		_____ Phone Number																																		
				_____ Date																																		
28. Employee was provided a copy of the SAR. <input type="checkbox"/> Yes <input type="checkbox"/> No																																						

Supervisor completes and submits report to Program Manager within 24 hours of accident.

HRD 414 Rev 02/2000

PART B: DEPARTMENT PREVENTION ACTIONS

Program Manager (can be a first-line supervisor, section, branch or division chief) completes the following:

29. ☐ Concur ☐ Do not concur with the supervisor's assessment of the accident for the following reasons:

30. **Do not delay processing.** Person that reviews the Supervisor's Accident Report (SAR) and forwards original to the **Departmental Personnel Officer (DPO)** or unit that prepares the WC-1 **within 2 working days** (copy to DPO). A copy is to be used to complete the prevention section and other areas designated as Part B of this form.

Date reviewed

Initials

Prevention Section

31. List actions taken or planned to prevent/minimize recurrence.

32. Indicate type of training related to the accident employee received prior to the injury/illness. Is additional training or retraining being considered?

33. Name of organization and person responsible to complete prevention activities and indicate start and projected completion dates.

Organization

Person

Date Started

Date Completed

Program Manager signs the SAR and forwards report to Division Chief for Division prevention activities.

Program Manager Name

Program Manager Signature

Position Title

Phone

34. **Division Chief Review:** State actions to prevent similar accidents throughout the division.

Division Chief Signature

Date

35. **Departmental Personnel Officer, Safety Officer or Safety Council Representative:**

State actions to prevent similar accidents throughout entire department.

Departmental Personnel Officer, Safety Officer,
or Safety Council Representative Signature

Date

36. Disposition of report

☐ WC-1

☐ OSHA 200

☐ For Record only

Cause of Accident Example: An employee falls from a ladder. An "Unsafe act" is standing on a ladder and stretching to the side for an object beyond his reach. An "Unsafe condition" is not placing the ladder on stable footing or not securing the ladder. The ladder rung breaking while in use is an example of "defective equipment." The "lack of management action" is when management did not place a known defective ladder out of service or did not provide training on how to use the ladder properly.