**SUPERVISOR'S ACCIDENT REPORT**

**POLICY NO. 900.001 (Eff. 12/18/03)**

**Attachment B**

# 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 ☐ Male ☐ Female |
|---|---|---|---|

| 6. Department-Unit Name | 7. Employee's Title: | 8.Years in Position __ __. __ | 9.Location of Accident |
|---|---|---|---|

| 10. On State Property? ☐ Yes ☐ No | 11.Date of Injury/Illness ____/____/____ | 12. Accident Time ____ AM ____ PM | 13.Date Disability Began ____/____/____ | 14.Date Reported ____/____/____ |
|---|---|---|---|---|

| 15. Weather Condition: ☐ Sunny ☐ Rainy ☐ Windy ☐ Other ____________ | 16. Appt. Type: ☐ Permanent ☐ Temporary ☐ 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?)

21. Identify tools, equipment or materials the employee was using.

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).

20. Indicate the type of personal protective equipment issued to the employee and if used at the time of the accident.

| | Issued | Used |
|---|---|---|
| Head | O | O |
| Eye/Face | O | O |
| Body | O | O |
| Hand - Arm | O | O |
| Foot-Leg | O | O |
| Respiratory | O | O |
| Ear | O | O |

State type of protection ________________

________________

24. Has employee ever had a similar injury/illness? ☐ No ☐ Yes If yes, give date(s):

25. What is the cause of the accident? ☐ Unsafe Acts(s) ☐ Unsafe Condition(s) ☐ Motor Vehicle ☐ Defective Equipment/Tools/Hardware ☐ Management Inaction ☐ 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. ☐ Yes ☐ 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

## SUPERVISOR'S ACCIDENT REPORT

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**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.