# 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 _____

**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.

# INSTRUCTIONS FOR COMPLETING THE STATE OF HAWAII SUPERVISOR'S ACCIDENT REPORT (HRD 414 Rev 06/2012)

Purpose: Supervisors are responsible for investigating, reporting, and initiating procedures to eliminate the cause of injuries or illnesses to prevent recurrences. The Supervisor's Accident Report (SAR) form provides a standardized, systematic format for the supervisor to attaining this purpose. The form may also be used to record incidents where no injury/illness occurred, but accident prevention activities should be taken.

General Instructions: The following are instructions for completing the Supervisor's Accident Report Form. Departments may make modifications as necessary to meet their specific needs.

All claims for injuries/illnesses must be reported to the supervisor and recorded on the Supervisor's Accident Report Form. Part A (Items 1-35) serves as the supervisor's initial report of an accident and should be completed within 24 hours of the occurrence and forwarded to your Departmental Personnel office for completion of WC-1 (Employer's report of industrial injury) form. The completed page one of this form and the WC-1 must be sent to Department of Human Resources Development (DHRD) immediately to meet the Department of Labor and Industrial Relations (DLIR) Disability Compensation Division's reporting requirements.

Part B (investigation portion) should be completed as more information becomes available after considerations or activities have been determined to mitigate injury/illness causal factors.

The report must be completed as thoroughly and accurately as possible for it to be of use. Although the supervisor should discuss the accident with the injured employee to accurately report the facts, it is the supervisor's responsibility to complete the accident description portion of the form.

Copies of the report should be given to the employee and included in the department's injury/illness claim files. This report is also to be used when the employee makes reports for "record only" and a WC-1 is not submitted. WC-1's should be submitted only for injuries causing absence from work for one day or more or requiring medical treatment beyond first aid.

# SUPERVISOR'S ACCIDENT REPORT
# FORM COMPLETION INSTRUCTIONS

| Item No. | Instruction |
|---|---|
| | Part A: Accident Report |
| 1 | Enter the date this form was prepared using a 6 digits: mm/dd/yy. |
| 2 | Enter the injured employee's last name, first name, and middle initial, if any. Do not use nicknames. |
| 3 | Enter the employee's social security number. |
| 4 | Enter the employee's age at the time of injury. |
| 5 | Place an (X) in the appropriate box. Male or female. |
| 6 | Enter the name of the department and unit in which the injured employee works. |
| 7 | Enter employee's class title, e.g. Janitor III, Accountant IV, or Personnel Technician V. |
| 8 | Enter the number of years (rounded off to the nearest tenth) that the employee has been in that particular position and grade level. Examples: 12.0, 3.6, 0.4 years. |
| 9 | Enter the address or brief description of where the accident occurred. Example-235 Maile Street, Kailua-Kona or 3rd floor Ewa steps of the Keeliokolani Bldg. |
| 10 | Check the appropriate box to indicate if the accident occurred on State property. |
| 11 | Enter the date the accident occurred. If the exact date is unknown, enter an estimated date of when the injury or illness began or when employee became aware of the injury or illness. |
| 12 | Enter the time of day the accident occurred. |
| 13 | If the employee could not complete the workday because of accident, enter the day of the accident. If the employee completed work the day of the accident, but was later unable to work, enter the date the disability started. |
| 14 | Enter the date the accident was first reported or made known to the employer. |
| 15 | Check the appropriate box. Examples of other conditions maybe: thunder, lightning, hail, eclipse, etc. |
| 16 | Check the appropriate box for the type of appointment, permanent or temporary. Permanent appointments refer to regular civil service employees hired for a permanent position. Temporary appointments refer to appointments with an end or termination date such as provisional, limited term, temporary appointments outside of list, emergency hires, and exempt appointees under Chapter 76-16, Hawaii Revised Statutes (HRS). Other refers to any appointments that are neither permanent or temporary such as volunteers performing service for the State as defined under Chapter 386-171, HRS. Enter termination date for temporary appointments. |

# SUPERVISOR'S ACCIDENT REPORT
# FORM COMPLETION INSTRUCTIONS

| Item No. | Instruction |
|---|---|
| 17 | Enter the name of the physician treating employee's injury. |
| 18 | Enter treating physician's address and telephone number. |
| 19 | Describe in detail what employee was doing when he/she got injured, including events which occurred that led to the accident. |
| 20 | Check the appropriate box or boxes to indicate which personal protective equipment was issued to the employee and if used at the time of the accident. |
| 21 | List any tools, equipment or materials that employee was using when injury occurred. Examples: floor polisher, file cabinet, stapler, hand truck, etc. |
| 22 | Describe the nature of injury or illness which is claimed and the specific part of body affected by the injury or illness (Use medical report, if available). Examples of nature of injury include: bruise, laceration, strain, sprain, repeated trauma, heart attack, stress etc. Examples of part of body include: left eye, right elbow, respiratory system, cardiovascular system, brain, lower back, etc. |
| 23 | List the names and telephone numbers of any witnesses to the accident. Obtain witness statements--use witness statement form (see attached). |
| 24 | Check the appropriate box and provide an approximate date if the answer is yes. |
| 25 | Check the appropriate box and explain how the item checked contributed to the accident/injury. Refer to the example on page 2 of the SAR for clarification. |
| 26 | Provide reasonable measures that could have been taken by either the injured employee or another party which would have resulted in the accident not occurring. |
| 27 | The immediate supervisor that completed Part A of the accident investigation report form prints his name, signs, provides his work telephone number and indicates the date on the form. |
| 28 | Check the appropriate box. |
| 29 | Forward Part A to DPO. Copy of the report is submitted to the Program Manager and Division Chief for accident prevention action. |

SUPERVISOR'S ACCIDENT REPORT
FORM COMPLETION INSTRUCTIONS

| Item No. | Instruction |
|---|---|
| | Part B: Investigation Report |
| 29 | Check the appropriate box (Concur or Do not concur) and provide an explanation of why that box was checked. |
| 30 | Program Manager (may be unit supervisor, section head, branch manager, principal, or designee) to review Part A, indicate the date Part A was reviewed and forwarded for WC-1 preparation. Put initials on the line indicated. The original is forwarded to the DPO or unit that prepares the WC-1 and a copy is made to complete Part B of the form. An additional copy is made for the DPO if the original is not forwarded to the DPO. |
| 31 | List actions taken or planned to prevent/minimize recurrence. |
| 32 | Describe applicable training, date of training, and equipment employee received to perform the job safely. |
| 33 | Indicate the name of organization or individual responsible to prevent recurrence of the incident. Also indicate the start date and projected completion date of the project or modified procedure. |
| 34 | Division Chief reviews investigative report and states actions to prevent similar accidents on division level. Division Chief signs and date as indicated. |
| 35 | Departmental Personnel Officer, Safety Officer or Safety Council Representative reviews investigative report and states actions to prevent similar accidents throughout the department. This person should also review the report for completeness, determine if appropriate action is being taken and utilize report information in managing the overall departmental safety program. If the report is not adequately completed, it should be returned to the unit head of the reporting supervisor with a request for prompt completion and resubmittal. |
| 36 | Check the box "WC-1 submitted" if it is likely that the injured person will be making a workers' compensation claim, the incident involves a third party who might be held liable for charges, or there are other expected costs (e.g. time loss/medical costs).<br>Check the box "OSHA 300" if the incident is an OSHA recordable case as defined in the instructions on the back of form OSHA No. 300.<br>Check the box "for record only" if there was no disability or expected costs and the report is being made only to have a record of the incident. |
| 37 | Departmental Personnel Officer, Safety Officer, or Safety Council Representative signs and dates form. |