

# Leech Lake Band of Ojibwe

## Supervisor's Accident Investigation Report

Employee Name Last First Middle			Social Security #:		
Address			Phone No.		
Job Title		Dept. No.	Department Name		
Location of Accident (be specific)			Date/Time of Accident		
Medical Treatment Received:		General First Aid:		Lost Time From: To:	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		_____	
Hospital/Clinic:				(Mo. Day Year) (Mo. Day Year)	
Yes <input type="checkbox"/> No <input type="checkbox"/>					
Length of time on this job:		Regular Job?		Other Employment: If so where?	
_____		Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Description of type of injury and body part affected:					
Observe accident site; ask questions; determine facts, describe. <b>ATTACH PHOTOS</b>					
Description Of Accident		Witness Name: Address: City: State: Zip: Phone Number: ( ) -			
Cause Of Accident		Consider unsafe acts and/or conditions contributing to accident. Check all that apply and describe. Comments:			
		<input type="checkbox"/> Not following supervisor's instructions <input type="checkbox"/> Not following correct procedures <input type="checkbox"/> Lack of training/procedures <input type="checkbox"/> Incorrect use of equipment <input type="checkbox"/> Job requires different equipment <input type="checkbox"/> Defective equipment		<input type="checkbox"/> Poor housekeeping <input type="checkbox"/> Defective floor, stairs, etc. <input type="checkbox"/> Horseplay <input type="checkbox"/> No personal protective equipment <input type="checkbox"/> Repetitive	
Corrective Action		Consider corrective action for people premises and machines. A. Describe immediate corrective action taken:  B. Describe any further correction taken: Warning issued? Yes <input type="checkbox"/> No <input type="checkbox"/>  Will work order or purchase order be necessary? Projected completion date: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Safety Director Signature		Date	Actual Completion Date:		
Supervisor Signature		Date	Dept. Mgr. Or Director Signature		Date
Employee Signature		Date			
Complete this form and distribute to the Safety Director at <a href="mailto:healthandsafety@leechlakegaming.com">healthandsafety@leechlakegaming.com</a> and Department Manager within 2 days of Accident.					
Revised 04/11/2022					

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