

SUPERVISOR'S INVESTIGATION REPORT

To assist our loss control efforts, please identify the factors causing the loss and state the remedy proposed or taken to prevent future occurrences.

Member (City/Utility Name):		Department:
Location of Accident:		Date & Time of Accident:
Name of Injured Worker:	Injured Worker's Department:	Injured Worker's Job Title:
Description of Injury:		
Description of Accident:		
Unsafe Condition Causing or Contributing to the Accident (Poor lighting, oily surface, guards missing or not functioning, etc.):		
Unsafe Act or Work Procedure (Guard removed, adjusting moving machine, a specific item of substandard performance or procedure, etc.):		
What action has been taken or is proposed to prevent same or similar event:		
Supervisor:	Reviewed & Approved by:	Date of Report:

(Use the reverse side for diagram or additional detail)



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