

## CITY OF RACINE SUPERVISOR REVIEW OF INJURY OR ILLNESS

*Fax This Form to Human Resources at 262-636-9585*

Employee Name (First, Middle, Last)	Injury Date Mo/Day/Yr
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***This form is to be completed by the employee's supervisor. Please provide information that will supplement the employee's report, noting circumstances which may have contributed to the injury or illness, such as weather conditions, use of protective safety equipment, etc. Be thoughtful and thorough, seeking to identify operations, procedures, use of equipment or modification that could help reduce future incidents.***

**UNSAFE ACT / CONDITION:**

- |  |   |
|--|---|
| <input type="checkbox"/> Housekeeping                        | <input type="checkbox"/> Materials/tools                            |
| <input type="checkbox"/> Work Practices                      | <input type="checkbox"/> Hazards not recognized                     |
| <input type="checkbox"/> Safeguarding devices                | <input type="checkbox"/> Protective equipment                       |
| <input type="checkbox"/> Physical and environmental stresses | <input type="checkbox"/> Exceeding limits (speeds, strengths, etc.) |
| <input type="checkbox"/> Facility/design                     |   |
| <input type="checkbox"/> Other: _____                        |   |

**CONTRIBUTING FACTORS:**

- |  |  |
|--|--|
| <input type="checkbox"/> Equipment failure   | <input type="checkbox"/> Repetitive Motion/Ergonomics                          |
| <input type="checkbox"/> Used wrong equipment                                      | <input type="checkbox"/> Work Station/Ergonomic                                |
| <input type="checkbox"/> Housekeeping/Maintenance                                  | <input type="checkbox"/> Failure to use protective equipment/devices           |
| <input type="checkbox"/> Procedure Factors   | <input type="checkbox"/> Safety Policy/Rule Violation                          |
| <input type="checkbox"/> Improper Body Mechanics (i.e. Improper Lifting, carrying) | <input type="checkbox"/> Unsafe Act  |
| <input type="checkbox"/> Slippery or defective floor/work surface                  | <input type="checkbox"/> Environmental exposure to toxic substance, noise etc. |
| <input type="checkbox"/> Knowledge / skills lacking                                | <input type="checkbox"/> Horseplay   |
| <input type="checkbox"/> Substance abuse   |  |
| <input type="checkbox"/> Other: _____  |  |

**CORRECTIVE ACTION (Attach additional pages, if necessary):**

Action to be Taken to Prevent Recurrence:	Responsible Party:	Completion Date:
1		
2		
3		

Supervisor Signature:	Date Signed
Department Manager Signature:	Date Signed