Division of School Plant Operations (SPO)
Supervisor's Incident Investigation Report of Occupational Injury

MCPS CLEAR FORM

Supervisors are responsible for calling CorVel Corporation at **1-888-606-2562** to file Employer's First Notice of Loss (FNOL) within ***24 hours of incident***.

FOR A FATALITY OR HOSPITALIZATION, CALL 301-370-2141 IMMEDIATELY

EMPLOYEE INFORMATION

Name _____ ID Number_____ Date of Birth ____/____/_____

School/Facility_____ Work Phone_____

Job Title _____ Date of Hire ____/____/_____ Gender ☐ Male ☐ Female

Scheduled Hours Per Week ☐ 40 Hours ***or*** ____ number of hours Time Work Began ___:___ ☐ a.m. ☐ p.m.

Reported to Immediate Supervisor? ☐ Yes ☐ No Reported to Building Service Supervisor? ☐ Yes ☐ No

DETAILS OF INJURY, ILLNESS, EXPOSURE OR INCIDENT

Date of injury ____/____/_____ Time of injury ___:___ ☐ a.m. ☐ p.m. ☐ Daylight ☐ Dark

Specific injury and body part affected _____

Medical diagnosis determined ☐ Yes ☐ No

Was Employee seen by a medical professional? ☐ Yes ☐ No

Did Employee receive medical evaluation and/or treatment? ☐ Yes ☐ No

Date of Supervisor's first knowledge/notice of injury ____/____/_____

Was Employee hospitalized overnight? ☐ Yes ☐ No Date of Death (if applicable) ____/____/_____

Reported to Systemwide Safety Programs? ☐ Yes ☐ No Fax: 301-279-3061

Reported to Risk Management Specialist, ERSC? ☐ Yes ☐ No Fax: 301-279-3642

INVESTIGATION OF INJURY, ILLNESS, EXPOSURE OR INCIDENT

Incident location (specify location, room, etc.)_____

On MCPS premises? ☐ Yes ☐ No School/Facility where Event Occurred_____

Were others injured? ☐ Yes ☐ No

Equipment, tools, materials, or chemicals the Employee was using when the event or exposure occurred (broom, mower, vacuum, etc.)

_____

_____

Describe the specific activity employee was performing when event or exposure occurred (waxing floor, descending stairs, etc.)

_____

_____

_____

Was this injury/illness/incident caused by contributing factors (job practices, acts, etc.)? ☐ Yes ☐ No If YES, explain:

_____

_____

_____

Was this injury/illness/incident caused by an unsafe condition? ☐ Yes ☐ No If YES, explain:

_____

_____

_____

DETAILS OF INCIDENT CAUSED BY CONTRIBUTING FACTORS

If incident was caused by unsafe job practice, is there a Written Operating Procedure for this activity? ☐ Yes ☐ No

If Employee did not follow procedure, why not? _____

_____

_____

_____

Was Employee trained on this procedure? ☐ Yes ☐ No Training Date ____/____/_____

Describe in detail the corrective action taken (training, progressive discipline, etc.) _____

_____

_____

_____

Have other accidents occurred with same process or procedure? ☐ Yes ☐ No

_____

_____

Does training need to be changed to better address this hazard? ☐ Yes ☐ No

_____

_____

Does work practice or written procedure need to be changed/updated to better address this hazard? ☐ Yes ☐ No

DETAILS OF INCIDENT CAUSED BY HAZARDOUS CONDITION

Is the responsibility for safety inspections in this area assigned? ☐ Yes ☐ No If YES, to whom? _____

Have Site Safety Inspections been conducted according to a schedule? ☐ Yes ☐ No

Date of last Site Safety Inspection ____/____/_____

Did the hazardous condition exist at the time of the last inspection? ☐ Yes ☐ No

If defective equipment was involved, has it been taken out of service? ☐ Yes ☐ No ____/____/_____

Has the hazardous condition been previously identified? ☐ Yes ☐ No ☐ Verbally ☐ Written

If hazard was previously identified, were actions taken to correct or mitigate the hazard? ☐ Yes ☐ No

If YES, nature of correction or mitigation steps taken _____

_____

_____

If NO, explain why no action was taken_____

_____

_____

SUPERVISOR'S INFORMATION

What action(s) are you taking, as a Supervisor, to prevent future incidents of this type? (Select all that apply)

☐ Correct Unsafe Condition
☐ Retrain Employee(s)
☐ Discipline Employee
☐ Implement/Revise Operating Procedure
☐ Revise Training Program
☐ Modify/Upgrade Work Tools
☐ Communicate Facts and Prevention Tips with Employee and Other Employees
☐ Conduct More Frequent Safety Checks
☐ Other (specify)_____

Supervisor's Name/Title_____

Department/Depot_____ Work Phone_____

Supervisor's Signature _____ Date ____/____/_____

Distribution: 1. Building Service Supervisor
2. Principal or Facility Administrator
3. Systemwide Safety Programs Team Leader, DFM, 45 W. Gude Drive, Suite 4000, Rockville
4. Risk Management Specialist, ERSC, 45 W. Gude Drive, Suite 1200, Rockville