

SUPERVISOR'S MISHAP REPORT

WHO WAS INVOLVED

Name of Individual Involved (<i>Last, First, Middle Initial</i>):		Full Social Security#	Rank	Job Title:	NEC:
		- -			
Date of Birth:	<input type="checkbox"/> Male	Duty Status:		Assigned Work Center:	
____/____/____	<input type="checkbox"/> Female	<input type="checkbox"/> On Duty <input type="checkbox"/> Off Duty <input type="checkbox"/> TAD		Years Experience in present job:	
Month Day Year				At task during the mishap:	
				(Military Only) <input type="checkbox"/> Married <input type="checkbox"/> Single # Dependents:	

WHERE & WHEN DID IT OCCUR

Mishap Location (<i>Office, Clinic, Parking Lot, On-Base, Off-Base, etc.</i>):	Date of Mishap:	Time of Mishap:
	____/____/____	____:____:____
	Month Day Year	(24Hr Clock):

WHAT AND HOW IT OCCURED

Describe what happened:	Resulting injuries:
	<input type="checkbox"/> Bruise/Contusion <input type="checkbox"/> Muscle Tear
	<input type="checkbox"/> Cut <input type="checkbox"/> Sprain
	<input type="checkbox"/> Needle Stick <input type="checkbox"/> Loss of consciousness
Describe how it happened:	<input type="checkbox"/> Strain <input type="checkbox"/> Electric Shock
	<input type="checkbox"/> Break/Fracture <input type="checkbox"/> Other _____
	<input type="checkbox"/> Illness <input type="checkbox"/> Ergonomically related

Part of the body affected:	Equipment Involved:	Number of Lost Work Days*:
<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> None <input type="checkbox"/> Government Vehicle*	_____ *Count only workdays following the day after the injury; do not count if less than one workday
<input type="checkbox"/> Leg <input type="checkbox"/> Shoulder	<input type="checkbox"/> Private Vehicle <input type="checkbox"/> Other _____	First Lost Work Day: ____/____/____
<input type="checkbox"/> Knee <input type="checkbox"/> Arm	Estimated Damages (\$): _____	Returned to Work: ____/____/____
<input type="checkbox"/> Foot <input type="checkbox"/> Elbow	*Ensure any damage to government property is reported to the Facility Manager	-----
<input type="checkbox"/> Toe(s) <input type="checkbox"/> Hand	Protective Equipment Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Restricted (Light) Duty Days:
<input type="checkbox"/> Head <input type="checkbox"/> Finger(s)	Protective Equipment Available: <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Days Hospitalized:
<input type="checkbox"/> Eye(s) <input type="checkbox"/> Torso	Protective Equipment Used: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Other _____		

WHY IT OCCURRED

Root Cause:	Contributing Factors (<i>fatigue, lighting, haste, etc.</i>):
<input type="checkbox"/> Inattentiveness <input type="checkbox"/> Inadequate Training <input type="checkbox"/> Work Process	
<input type="checkbox"/> Other party is responsible <input type="checkbox"/> Other: _____	

Corrective action to prevent recurrences (Provide PPE, tools, develop SOP, train, etc.):	Treatment:
	First Aid Only <input type="checkbox"/> Yes <input type="checkbox"/> No
	Sought medical care <input type="checkbox"/> Yes <input type="checkbox"/> No
	Medical care facility consulted: _____
	Medical Diagnosis: _____

(1) Supervisor Preparing Report: Print: _____ Signature: _____	(2) Signature of Higher Level Reviewer: Print: _____ Signature: _____
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(3) SOH Manager Comments:

Signature: _____ Date Received: _____

FOR OFFICIAL USE ONLY

The Health Information Portability and Accountability Act provides an exception for medical treatment information used to complete safety investigations/reports (OPNAVINST 5102.1). FOUO documents containing personal information shall be handled per SECNAVINST 5510.36.