Competency/Serial Number:

Date:

SUPERVISOR'S REPORT OF INJURY

Submit completed form to the Occupational Safety and Health (OSH) Office

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; E.O. 9397 (SSN); E.O. 12196, Occupational Safety and Health Programs for Federal Employees; DoD Instruction 6055.7, Accident Investigation, Reporting, and Record Keeping; OPNAVINST 5102.1 series, Mishap Investigation and Reporting; and MCO P5102.1B, Marine Corps Ground Mishap Investigation and Reporting Manual.

PURPOSE: To collect information on injuries and occupational illnesses required of Federal governmental agencies by the Occupational Safety and Health Administration (OSHA). The summary data of occupational injuries or illnesses maintained in this system will be used for analytical purposes to improve the Department of the Navy's accident prevention policies, procedures, standards, and operations, as well as ensure internal data quality assurance.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, these records or information contained therein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: The DoD 'Blanket Routine Uses' that appear at the beginning of the Navy's compilation of systems of records notices apply to this system.

DISCLOSURE: Disclosure of requested information is voluntary, however, failure to provide such information may result in a delay of your processing any injury claims.

SUPERVISOR INFORMATION

IMMEDIATE SUPERVISOR (Last, First, MI)	COMPETENCY	TELEPHONE	SUPERVISOR NOTIFIED DATE/TIME

SUPERVISOR AT TIME OF INJURY (Last, First, MI)	TIER 3 (Last, First, MI)	TIER 2 (Last, First, MI)

DATA ON INJURED PERSON

NAME (Last, First, MI)	SSN (Last Four)	GENDER	AGE	DATE/TIME OF INJURY	OCCUPATION

COMPETENCY	TELEPHONE	MONTHS AT ACTIVITY	MONTHS AT OCCUPATION	NATURE OF INJURY

BODY PART(S) INJURED	DATE WORK STOPPED	DATE RETURNED TO WORK	RESTRICTED DUTY DAYS

LEAVE TYPE	INJURED PERFORMING ROUTINE DUTIES	If NO, explain
☐ AL ☐ SL ☐ COP	☐ YES ☐ NO	

TYPE OF SAFETY TRAINING (Past Year)

ACCIDENT DATA

LOCATION (Be specific)	SAFETY OFFICE NOTIFIED DATE/TIME

EVOLUTION AT TIME OF ACCIDENT	MATERIAL/EQUIPMENT INVOLVED

INJURED TREATED WHERE/WHEN (Employee is required to check in and out of dispensary)

DISPENSARY	HOSPITAL	PRIVATE DOCTOR

DESCRIPTION OF ACCIDENT (Include all apparent causes of actions that may have led to the accident)

SUPERVISOR'S ACTIONS TO PREVENT RECURRENCE

WITNESS INFORMATION

WITNESS 1 NAME (Last, First, MI)	COMPETENCY	TELEPHONE	WITNESS 2 NAME (Last, First, MI)	COMPETENCY	TELEPHONE

APPROVAL

SUPERVISOR NAME AND TITLE (Printed name)	DATE	SIGNATURE

OCCUPATIONAL SAFETY AND HEALTH (OSH) USE ONLY

CASE NUMBER	TYPE	LEAVE/CONTINUATION OF PAY	INVESTIGATION REQUIRED
	☐ LT ☐ NLT ☐ RD ☐ MED/E	☐ YES ☐ NO	☐ YES ☐ NO

DIRECT CAUSE OF INJURY

INDIRECT CAUSE OF INJURY

DISPENSARY DATE/TIME CHECKED IN	DATE/TIME CHECKED OUT

WAS THERE AN AWARENESS OF THE UNSAFE CONDITIONS OR EQUIPMENT?

☐ YES ☐ NO

WAS THERE AN AWARENESS THAT THE PRACTICES WERE CONSIDERED UNSAFE?

☐ YES ☐ NO

WHAT HAS BEEN DONE TO CORRECT THE CONDITIONS?

RECOMMENDATION(S)/CORRECTIVE ACTIONS

STATE ANY OTHER LOCATION TO WHICH RECOMMENDATIONS ARE APPLICABLE

APPROVALS

SUPERVISOR - When notified of findings (Printed name)	DATE AND TIME	SIGNATURE
REPORT INVESTIGATED BY (Printed name)	DATE	SIGNATURE
HEAD, OSH OFFICER (Printed name)	DATE	SIGNATURE