Please check your group from the list below.

- ❑ Massachusetts Retail Merchants Workers' Compensation Group, Inc.
- ❑ Massachusetts Care Self-Insurance Group, Inc. (nursing homes)
- ❑ Massachusetts Healthcare Self-Insurance Group, Inc. (hospitals)
- ❑ Massachusetts Manufacturing Self-Insurance Group, Inc.
- ❑ Massachusetts Trade Self-Insurance Group, Inc.

P.O. Box 859222-9222 / Braintree, MA 02185 / (781) 843-0005 / 800-790-8877 / Fax (800) 382-8891

Supervisor's Investigative Report

This is a follow-up report used to indentify and correct conditions or practices which have led to an employee work-related incident.

Employer's Name: _____

I. GENERAL INFORMATION

Employee Name _____ Department _____

Supervisor Completing This Form _____ Date of Incident _____ Date Supervisor Notified _____

II. INTERVIEW WITH FIRST PERSON NOTIFIED OF INCIDENT

Name of Person _____ Date Person was Notified _____

III. INTERVIEW EACH WITNESS (Name and Statement)

_____

_____

_____

IV. WHERE DID THE INCIDENT OCCUR?

_____

_____

_____

V. DESCRIBE WHAT HAPPENED AND THE REASON(S) INCIDENT OCCURRED

_____

_____

_____

VI. WHAT ACTION WAS TAKEN TO PREVENT A RECURRENCE?

_____

_____

_____

VII. SIGNATURE

Signature of Supervisor Completing Form _____ Date Completed _____

Signature of Safety Officer _____ Date Reviewed by Safety Committee _____

VIII. IMPORTANT

If equipment or machinery was the cause of the incident, please advise the claims department of any service contracts.