Department of Transportation (DOT)
Supervisor's Incident Investigation Report of Occupational Injury

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 ____/____/_____

Work Phone ______________________ Date of Hire ____/____/_____ Gender ☐ Male ☐ Female

Job Title ____

Depot ☐ Bethesda ☐ Clarksburg ☐ Randolph ☐ Shady Grove N ☐ Shady Grove S ☐ West Farm

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 Bus Operations Manager? ☐ 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, bus lot, bus number, etc.)______________________

On MCPS premises? ☐ Yes ☐ No

School/Facility where Event Occurred (Route #/Road) ______________________

Were others injured? ☐ Yes ☐ No

Equipment, tools, materials, or chemicals the Employee was using when the event or exposure occurred (broom, wheel chair lift, changing tire, etc.)______________________

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____

Describe the specific activity employee was performing when event or exposure occurred (driving/making turn, descending stairs, etc.

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____

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

____

____

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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? ______________________________

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____

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

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

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

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

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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/vehicle 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 ______________________________

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If NO, explain why no action was taken______________________________

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SUPERVISOR'S INFORMATION

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

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

☐ Other (specify)______________________________

Supervisor's Name/Title______________________________

Department/Depot______________________________ Work Phone______________________

Supervisor's Signature ______________________________ Date ____/____/_____

Distribution:
1. DOT Supervisor
2. DOT Depot Manager
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