Kern County Sheriff's Office

Policies and Procedures

TITLE: SUPERVISOR'S INVESTIGATION REPORT			NO: N-220
APPROVED: **Donny Youngblood, Sheriff-Coroner**			
EFFECTIVE: September 15, 1993	REVIEWED: 05/11/2018	REVISED: 1/22/2009	UPDATED: 05/11/2018

POLICY

The **SUPERVISOR'S INVESTIGATION REPORT** form is used to detail the results of a supervisor's investigation into all reported work-related accidents, injuries, illnesses, or exposures to infectious or hazardous material, to the Sheriff's Office and the County. Do **not** use this form for non-injury vehicle accidents.

The **SUPERVISOR'S INVESTIGATION REPORT** form is also used to document any work-related injury or illness when there is **NO** medical treatment beyond first aid and **NO** lost time beyond the date of injury to the Sheriff's Office and the County.

Attached is a copy of a **SUPERVISOR'S INVESTIGATION REPORT** form (Exhibit A) with each line numbered. The following guidelines will be used to complete the form:

LINE #

1. Enter the **name of the employee** involved in the incident.
2. Enter the **date of birth** of the employee involved.
3. Enter employee's **County ID#,** (the number starting with "999").
4. Indicate the **gender** of the employee.
5. Enter the Sheriff's Office address of: **1350 Norris Rd. Bakersfield, CA 93308** (if not already listed).
6. Enter the Sheriff's Office phone number of **(661) 391-7500** (if not already listed).
7. Document the **date** and **time the injury occurred** and the **date and time the injured employee began his/her shift.**
8. The department is the **Kern County Sheriff's Office** (if not already listed).
9. Enter the **job title of the employee involved**.
10. Document the **nature and extent of the injury**.
11. State what **activity the employee was involved in** at the time of injury.
12. State whether or not the employee **sought treatment with a doctor/hospital – Yes or No**.

13. State whether or not the employee was able to **complete his/her shift – Yes or No.**

14. State whether or not the employee went to the **Emergency Room for treatment – Yes or No.**

15. State whether or not the employee was made an **inpatient and hospitalized overnight – Yes or No.**

16. Enter the **name and address of the hospital** where the employee was treated.

17. **Leave blank** as you are not going to know how many days, if any, the employee will be off from work due to his/her illness or injury.

18. This section provides **boxes for you to select**. Look at the various lists, find the most appropriate box and enter a check mark. If nothing seems appropriate, use the box at the bottom of the list and write in the appropriate response on the line adjacent to the box.

19. State the **location of the accident** and **detail what occurred.**

20. List the **name(s) of any witness(es) to the incident or accident.**

21. State the **cause of the incident or accident**.

22. List what **corrective action** was taken, will be taken, or is recommended, to prevent this from happening again.

23. The Supervisor prints his/her name, then **signs and dates** when the form was completed.

24. The Department Head may enter his/her concurrence/comments.

25. The Department Head prints his/her name, then signs and dates when he/she has reviewed the findings of the report.

End of form.

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