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) 843-005 • (800) 790-8877 • Fax (800) 382-8891

SUPERVISOR'S INVESTIGATIVE REPORT

This is a follow-up report used to identify 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.