FARGO PARK DISTRICT
SUPERVISOR INVESTIGATION REPORT

This report is to be completed by the Supervisor of an employee who has sustained an injury. The completed report should be returned to safety@fargoparks.com

Employee Name: _____ **Job Title:** _____

Department: _____

Location of Injury/Incident_____

Date of Injury/Incident: _____ **Time:** _____ ☐**AM** ☐**PM**

ANALYSES OF CAUSES

Immediate Cause:

_____

_____

Would safety equipment or training have prevented the accident? ☐YES ☐NO

If yes, brief explanation: _____

_____

CORRECTIVE ACTION

Corrective Action to Be Taken: _____

_____

_____

By Whom: _____ Date When: _____

Investigated By: _____ Dated: _____

Department Director Review: _____Dated: _____

This form is to be attached to a copy of the Incident Reporting Form.

RETURN THIS FORM TO safety@fargoparks.com