SUPERVISOR'S SUPPLEMENTAL REPORT OF GSA EMPLOYEE INJURY/ILLNESS

(See reverse for instructions)

1. NAME OF EMPLOYEE	2. DATE OF ACCIDENT

3. IN YOUR OPINION WHAT WAS THE CAUSE OF THIS ACCIDENT.

4. WHAT CORRECTIVE ACTION WAS TAKEN OR IS CONTEMPLATED TO PREVENT A RECURRENCE OF SIMILAR ACCIDENTS.

5. WHAT PROTECTIVE CLOTHING/EQUIPMENT WAS REQUIRED FOR THE TASK. IDENTIFY WHICH WERE USED AND NOT USED.

6. IDENTIFY THE REQUIRED OCCUPATIONAL SAFETY AND HEALTH TRAINING AND THE DATE(S) TRAINING COMPLETED.

7A. IS EMPLOYEE ENROLLED IN MEDICAL PROGRAM(S) *(Specify)*	7B. DATE OF LAST EXAMINATION	7C. CLEARED FOR USE OF REQUIRED PROTECTIVE
☐ YES ☐ NO		☐ YES ☐ NO

8. FACILITY MANAGER'S REVIEW AND COMMENTS.

9. SIGNATURE OF APPROVING MANAGER	10. DATE

GENERAL SERVICES ADMINISTRATION

GSA FORM **3623** (4-91)

INSTRUCTIONS

You must attach a completed copy of this form to the CA1/CA2.

The supervisor of the employee shall provide additional information which includes the following details:

Item	Explanation
3	Investigative data which identifies the cause(s) of the injury/illness and the reason the cause(s) existed.
4	Corrective action taken or contemplated to correct the cause(s) of the injury/illness; the date taken or anticipated; and the person/office responsible to take the action.
5	Statement with respect to the use/nonuse of personal protective clothing and equipment, if protection was required.
6	Type of required training and date employee completed the training respective to the task being performed at the time of the accident.
7A	If yes, specify each separate program (e.g., asbestos, hearing conservation, lead, etc.).
7B	If employee is enrolled in the medical surveillance program, enter date of last medical examination.
8	The manager of the facility or activity must sign and date the form. Comments are optional.