

SUPERVISOR'S ACCIDENT REPORT

Employer _____ Organizational Code _____

Name of employee _____

Occupation _____

Location of accident _____

Date of accident _____ 20 _____ Time _____ AM
PM

Date Supervisor notified _____ 20 _____ Time _____ AM
PM

Was employee on duty at time of accident? _____

Did employee leave work? _____ Date _____ Time _____ AM
PM

Did employee return to work? _____ Date _____ Time _____ AM
PM

How did accident happen? (State specific job being done, machinery, tools or objects involved and factors contributing to the accident) _____

Names of witnesses _____

Nature of injury _____
(Cut, Bruise, Strain, etc.)

Part of body _____
(Right leg, left ankle, lower back, etc.)

Name and address of treating physician or hospital _____

Was accident caused by noncompany person or faulty equipment? _____ If yes

identify: _____

Were mechanical guards or other safe guards provided? _____

Was employee using them? _____

What corrective action has been taken to prevent similar accidents? _____

Date _____ 20 _____ Supervisor _____

Reviewed by: _____ Position _____

Follow-up Needed? _____ Date _____