SUPERVISOR'S REPORT OF ACCIDENT

INJURED OR ILL EMPLOYEE: _____

ACCIDENT DATE: _____ TIME: A.M. _____ P.M. _____

WITNESSES: _____

_____

JOB LOCATION: _____

_____

DID INJURED EMPLOYEE RETURN TO WORK THE SAME DAY?
YES: _____ NO: _____

WHAT WAS EMPLOYEE DOING AT TIME OF ACCIDENT? _____

_____

NATURE OF INJURY AND BODY PART: _____

_____

WAS FIRST AID OR MEDICAL ATTENTION GIVEN? YES: _____ NO: _____

IF SO BY WHOM? _____

DESCRIPTION OF OCCURRENCE: _____

_____

_____

_____

_____

_____

_____

CAUSE OF ACCIDENT: _____

_____

_____

MEASURES TAKEN TO PREVENT RECURRENCES: _____

_____

_____

_____

_____

SUPERVISOR:	DEPARTMENT:	DATE: