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: _________