

Supervisor Report Of Accident/Injury

Part 1 – Report (All boxes MUST be completed)

Name:		<input type="checkbox"/> Female <input type="checkbox"/> Male	
		Phone:	
Job Title:		Department:	
Date of Injury/Illness:		Date of Knowledge:	
Time of Day:	<input type="checkbox"/> AM <input type="checkbox"/> PM	Time Began Work:	<input type="checkbox"/> AM <input type="checkbox"/> PM
Gross Wages/Salary:	Employee Usually Works:		Employment Status:
\$ _____ per	_____ hours per day,	_____ days per week,	_____ total weekly hours
		<input type="checkbox"/> Reg, Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal	
Was a claim form provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Provided:	<input type="checkbox"/> Check here if the employee is still off work
Was the employee unable to work on any day after injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Last Day Worked:
Has employee returned to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Returned:	Medical treatment requested? <input type="checkbox"/> Yes <input type="checkbox"/> No
If medical treatment was received, name and address of physician:			
If hospitalized, name and address of hospital:			
Where did the accident or exposure occur? (address, city and county)			
Was injury on employer premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was anyone else injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What was the employee doing when injured? (be specific-identify tools, equipment, materials or chemicals employee was using)			
Specify parts of body injured:(i.e. burn to left arm, strain to back, etc.)			
Please list Names of Witnesses below: (be specific and accurate)			<input type="checkbox"/> Check here if there are witnesses
Does the employee have outside employment/activities? (if yes, please explain below) <input type="checkbox"/> Yes <input type="checkbox"/> No			
How did the accident or exposure occur? (Below describe fully the events that led up to and resulted in injury or occupational disease, tell what happened. Please use separate sheet if necessary.)			

I certify that I, as a supervisor of this employee, personally investigated this accident, and have completed this form.

Date: _____

Supervisor Signature: _____

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Part II – Supervisor Analysis (All boxes must be completed)

Statements of Witnesses: (be specific and accurate, please use separate sheet if necessary)

Was unsafe mechanical/physical/environmental conditions present at time of injury? (if yes, please explain below) Yes No

Object or substance that directly injured employee (e.g. the machine employee struck against or which struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin; in cases of strains, the object the employee was lifting, pulling, etc.:

Was an unsafe act by the injured or another person a cause or contributing factor to the injury? (be specific) Yes No

Was another person(s) responsible for the accident? (If yes, who and how?) Yes No

Was a Code of Safe Practice Violated? (If yes, which one?) Yes No

Does the Code of Safe Practices need to be amended to cover this type of injury/illness? Yes No

Was personal protective equipment used by the injured employee? Yes No

Would the use of personal protective equipment have prevented this injury? Yes No

What steps have been taken to prevent a similar accident?: (an explanation MUST be provided below)

I certify that I, as a supervisor of this employee, personally investigated this accident, and have completed this form.

Date: _____

Supervisor Signature: _____