Supervisor's Accident Investigation Report

This report is to be filled out as soon as the accident is reported by the injured person and returned to the Central Office immediately.

Name of person injured: _____ Age: _____

Department: _____ Employment status: ___ Full time ___Part time _____Volunteer

Job Title: _____ Hours into shift: _____ How long employed: _____

Date of accident: _____ Time of accident: _____ a.m./p.m. Date reported: _____

Type of injury/illness: _____ Body part affected: _____

Exact location of accident: _____

Specific activity when accident occurred: _____ Was accident site reviewed by supervisor: _____

Did supervisor interview injured person? ___ Yes ____ No Did supervisor interview eyewitnesses? __ Yes __ No

Exactly how did accident occur? Describe persons, action, equipment, conditions, etc. _____

_____

_____

_____

_____

Was employee using required safety equipment, materials, or chemicals? ____ Yes ____ No ____ N/A

What could have been utilized to prevent this accident? _____ Is it available? _____

Training: _____

_____

Communications: _____

_____

Policies/procedures: _____

_____

Inspections: _____

_____

Supervisor's Accident Investigation Report: (Continued)

Report of injured employee attached? ___ Yes ___ No Reports of eyewitnesses attached? ___ Yes ___ No

Was first aid administered on the scene? ___ Yes ___ No

Was employee taken to hospital/clinic? ___ Yes ___ No If so, by whom? _____

Do you expect this to be a lost time accident? ___Yes ___ No

What immediate action has been taken to prevent occurrence of a similar accident? _____

_____

_____

_____

_____

Upon completion of this investigation, sign and turn in to person in your facility who is responsible for filing Workers compensation claims.

_____ _____

Supervisor signature Date

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ROUTING

Department Head (if different than supervisor) comments: _____

_____

_____ _____

Department Head signature Date