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SUPERVISOR'S REPORT OF ACCIDENT

(PLEASE READ AND FOLLOW INSTRUCTIONS ON REVERSE SIDE)

EVERY ACCIDENT SHOULD BE INVESTIGATED AND THE CAUSES CORRECTED TO HELP PREVENT MORE ACCIDENTS FROM OCCURRING. DO NOT OVERLOOK THE SO-CALLED "UNIMPORTANT" OR "NEAR MISS" CASES. EXCEPT FOR CHANCE, THEY COULD ALSO HAVE BEEN VERY SERIOUS. IT IS ONLY BY THOROUGH INVESTIGATION THAT MANY OF THE REAL CAUSES OF ACCIDENTS CAN BE DETERMINED AND CORRECTED.

EMPLOYER's NAME: _____ **EMPLOYEE's** NAME: _____ DEPT./LOC.: _____

ACCIDENT DATE: _____ ACCIDENT TIME: _____ AM / PM DID EMPLOYEE LOSE TIME FROM WORK? ☐YES ☐NO

HOURS LOST ON DATE OF ACCIDENT: _____ HAS EMPLOYEE RETURNED TO WORK? ☐YES ☐NO IF YES, RETURN DATE: _____

EMPLOYEE'S JOB TITLE: _____ EMPLOYEE'S LENGTH OF SERVICE WITH EMPLOYER: _____

EMPLOYEE'S LENGTH OF TIME IN *CURRENT JOB DUTIES*: _____

PLEASE PROVIDE YOUR HONEST COMMENTS ON THE QUESTIONS BELOW. THIS IS NOT FOR THE PURPOSE OF ASSIGNING BLAME TO ANYONE!! YOUR ANSWERS MAY HELP KEEP ACCIDENTS FROM REOCCURRING.

1.	WAS THE INJURED EMPLOYEE PROPERLY INSTRUCTED IN SAFE & EFFICIENT METHODS OF DOING HIS/HER JOB?	☐YES	☐NO
2.	DID THE INJURED EMPLOYEE VIOLATE ANY INSTRUCTIONS?	☐NO	☐YES
3.	WAS THE INJURED EMPLOYEE WEARING NECESSARY PERSONAL PROTECTIVE EQUIPMENT?	☐YES	☐NO
4.	DID HOUSEKEEPING CONDITIONS *CAUSE* OR *CONTRIBUTE* TO THE ACCIDENT?	☐NO	☐YES
5.	DID HORSEPLAY *CAUSE* OR *CONTRIBUTE* TO THE ACCIDENT?	☐NO	☐YES
6.	WAS THE ACCIDENT *CAUSED* OR *CONTRIBUTED* TO BY SOMETHING IN NEED OF REPAIR?	☐NO	☐YES
7.	DOES THE ACCIDENT INDICATE THE NEED FOR ANY TYPE OF GUARDING?	☐NO	☐YES
8.	DID THE INJURED EMPLOYEE HAVE ANY BODILY DEFECT WHICH *CAUSED* OR *CONTRIBUTED* TO THE ACCIDENT?	☐NO	☐YES
9.	WAS THE ACCIDENT *CAUSED* OR *CONTRIBUTED* TO BY ANY UNSAFE ACT?	☐NO	☐YES
10.	DID THE INJURED EMPLOYEE REPORT THE INJURY TO YOU, THE SUPERVISOR, IMMEDIATELY? (Within **One Workday**)	☐YES	☐NO

ACCIDENT: (Describe what injured employee was doing at the time of the accident, exactly what happened, who else was involved, the nature of the injury and part[s] of the body affected -- Use a separate sheet, if necessary.) _____

_____

WITNESSES' NAMES: _____

UNSAFE ACTS: (What did the employee or another person do incorrectly?) _____

_____

_____

UNSAFE CONDITIONS: (What unguarded or unsafe condition of machinery, equipment, vehicles, buildings or premises was involved?) _____

_____

ACTIONS TAKEN: (What did you do to correct the conditions which caused this accident?) _____

_____

REMEDIES: (What should your organization do to prevent other accidents like this from reoccurring?) _____

_____

MEDICAL CARE: DID INJURED EMPLOYEE GO TO DOCTOR / CLINIC / HOSPITAL? ☐YES ☐NO IF YES, COMPLETE THE FOLLOWING:

NAME OF DOCTOR / CLINIC / HOSPITAL: _____ PHONE NO.: (____) _____

ADDRESS: _____ DATE OF INITIAL VISIT: _____

AS THE INJURED EMPLOYEE'S SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS' COMPENSATION? ☐YES ☐NO REASON(S) WHY OR WHY NOT: _____

_____

REPORT SUBMITTED BY: _____ DATE: _____