

Supervisor's Report of Accident

This report must be completed within 24 hours by the supervisor and forwarded to the Human Resources Assistant. All accidents or occupational diseases involving medical treatment or time loss from work must be reported to the Idaho Industrial Commission and the workers compensation Third Party Administrator in a timely manner.

Employee Name: _____ Telephone: _____

Department: _____ Job Title: _____

Employee Status: Full Time Part Time Seasonal Volunteer Other _____

Date of Accident: _____ Time of Accident: _____ On Employer Premise: Yes No

Exact location where accident occurred: _____

Description of Accident (fully describe what was employee doing; how he/she was doing it; and any physical objects involved including weights of materials handled, tools, machines, structures, or equipment involved):

Nature of Injury (fully describe nature and extent of injuries sustained including the body part(s) involved):

Was medical treatment received? Yes No If "Yes" list medical provider/facility: _____

Did the employee leave work or miss any time from work as a result of their injury? Yes No

If "Yes" provide the last date worked: _____ Did employee return to work? Yes No

Date employee returned to work? _____ Returned to: Regular Work Modified Work

Was employee paid in full for date of injury? Yes No

Supervisor evaluation- was this injury the result of (check all that applies):

<input type="checkbox"/> Unsafe condition	<input type="checkbox"/> Weather conditions	<input type="checkbox"/> Unsafe illumination or ventilation
<input type="checkbox"/> Unsafe act or poor judgment	<input type="checkbox"/> Unsafe speed	<input type="checkbox"/> Poor housekeeping /congestion
<input type="checkbox"/> Failure to use protective devices	<input type="checkbox"/> Poor ergonomics	<input type="checkbox"/> Horseplay
<input type="checkbox"/> Defective tools or equipment	<input type="checkbox"/> Unsafe material handling	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Lack of knowledge	<input type="checkbox"/> Lack of experience/training	_____

Was the accident witnessed? Yes No If "Yes", provide the following information:

Witnesses name: _____ Telephone: _____

Witnesses name: _____ Telephone: _____

Name of supervisor completing report: _____ Date: _____

Supervisor's Telephone: _____ Best time to call: _____

Division Director's Signature: _____ Date: _____

Submit completed report to Human Resources. Retain a copy for Division/Department record.