

Supervisor's Report of Accident

This report must be completed within 24 hours of an accident and forwarded to your Division Director and Human Resources. Investigate all near-miss, property damage and injury situations. This report will be utilized by Human Resources to prepare and submit the First Report of Injury when required by the State Industrial Commission.

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 employee was doing; work task involved, 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): _____

Medical treatment received? Yes No If "Yes" medical provider/facility _____

Did employee leave work? Yes No Date _____ Time _____ Hours Worked that Day _____

Did employee return to work? Yes No Date _____ Time _____ Regular Work Modified Work

What can management do to prevent recurrence of this type of incident, (include target dates on your actions)? _____

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 | _____ |

Did the supervisor investigation confirm a specific work related accident occurred? Yes No

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

Witnesses name(s): _____ Telephone: _____

Name of supervisor completing report: _____ Date: _____

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

Submit completed report to Human Resources; Retain a Copy for Division/Department Records.