Supervisor's Accident Report

To be completed immediately after accident, even when there is no injury.

Incident No.
Incident Date:
Reporting Date:

Name of Employee:__

_____

1. Location of accident:	**2. Age:**
3. Sex:	**4. Years of Service:**
5. Title/Occupation:	**6. Time on present job:**
7. **Department:**	**8. Date and time of Accident:**

9. Accident Category: **Motor Vehicle** ☐ **Property Damage** ☐ **Other**	**10. Severity of injury or illness:** **NONE** ☐ **Non-disabling** ☐ **Disabling** ☐ **Medical Treatment** ☐ **Fatality** ☐

11. Estimated amount of damage: $	**12. Location:**
13. Nature of injury or illness:	**14. Affected area:**

15. Causative agent most directly related to accident? (Object, substance, material, machinery, equipment and or other conditions)
16. Did weather conditions affect injury or illness? Please describe.
17. Unsafe mechanical/physical/environmental conditions at the time of accident? (be specific)
18. Unsafe act by injured and/or others that may have contributed to the accident (this question must be answered, be specific)
19. Personal factors: (improper attitude, lack of knowledge or skill, slow reaction fatigue)
20. Personal protective equipment required? (protective glasses, safety shoes, safety hat, safety belt, etc.)
21. What can be done to prevent a recurrence of this type of accident? (modification of machine, mechanical guards, correct environment, training, ect.)
22. Detailed narrative description: (how did accident occur, why, objects, equipment, tools used, circumstances, assigned duties, be specific)
23. Witnesses to accident:

(Please attached a separate sheet if necessary)

_____ _____

Signature of Supervisor Department Head

Supervisor's Appraisal

(Attach to Supervisor's Accident Report)

1. **In your opinion what action on the part of the injured (or ill) person or others contributed to this accident?**

2. **Your recommendation:**

Date:

_____

Signature of Department Head

3. **Name and address of Medical Care Facility used for initial contact:**

4. **Name and address of attending physician:**