

Supervisor's Accident Investigation Report

This form must be completed and turned in to Lita Biggs, Director of Business Operations within 5 days of the incident being reported.

Name of Person Injured: _____ Age or DOB: _____

Department/Building of person injured: _____ Job Title: _____

Employment Status: Full Time Part-time Volunteer

Shift Schedule: _____ Date of Workplace Accident/Injury: _____ Time of Accident/Injury: _____ 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? _____ Did supervisor interview eyewitnesses? _____

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? Yes No

Training: _____

Communications: _____

Policies/Procedures: _____

Inspections: _____

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

Was first aid administered on the scene? Yes No Do you expect this to be a lost time accident? Yes No

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

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

Any additional comments: _____

Date

Signature

Email Address