Supervisor's Accident Investigation Report

This form must be completed and turned in to McGee Stoller, HR Leader, 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 (left/right etc):_____

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	Printed Name	Email Address

Modified 9.24.2024