SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Company Name:			
Address:			
Telephone Number:			
Name of Injured or Ill Employee:		Employee Address:	
Age:	Sex:	Years of Service:	Time on Present Job
Title/Occupation:		Department/Supervisor:	
Date of Accident	Time of Accident:	Location of Accident:	
Severity of Injury or Illness:			
Non-Disability: Y☐ N ☐	Disability: Y☐ N ☐	Medical Treatment: Y☐ N ☐	Fatality: Y☐ N ☐
Estimated number of days from job:			
Unsafe mechanical/physical/environmental condition at the time of accident (be specific):			
Unsafe act by injured employee or any other contributing to the accident (be specific):			
Personal factors (attitude, lack of knowledge or skill, slow reaction, fatigue).			
Personal protective equipment required? (protective glasses, safety shoes, safety hat, safety belt)			
What can be done to prevent a recurrence of this type of accident? (modification of machine, mechanical guards, correct environment, training?			
Detailed narrative description of accident. (How did accident occur?)			
SUPERVISOR'S APPRAISAL AND RECOMMENDATION			
In your opinion, what action on the part of the employee contributed to this accident?			
Recommendation(s):			
Supervisor's Signature:		Date:	