

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Employee Name: _____ Employee's Language: _____

Client Company: _____ Hire State: _____

Regular Occupation: _____ Department: _____

Was Employee performing regular job duties at time of accident? Yes /No

Hours Worked Per Day: _____ Days Per Week: _____

Shift Begin & End Time: _____ to _____ Employee Paid for full day of injury? Yes /No

Department or Location accident occurred: _____

Incident Address (City/State/Zip Code): _____

Employer's Premises? Yes /No

Date of Accident: _____ Time of Accident: _____

Date/Time Reported: _____ Reported to Whom? _____

Describe Accident: _____

Supervisor: _____

Witnesses: _____

Type and Extent of Injury: _____

Medical Care Provided By: _____

Address & Telephone: _____

Did employee return to work? Yes /No Expected Return Date: _____ Actual Return Date: _____

Number of Days Expected to Miss: _____

Did employee violate any established safety rule? Yes /No If Yes, explain: _____

Was there an equipment malfunction? Yes /No Signs of Drug/Alcohol Use? Yes /No

Was a Third Party Responsible for incident? Yes /No If Yes, explain: _____

Was personal protection required? Yes /No Was personal protection worn? Yes /No

Supervisor's Comments: _____

Investigated By: _____ Date: _____