

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Date: _____ Employee Name: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Social Security #: _____ DOB: _____ Sex: ____ Phone #: _____

Job Title: _____ Hire Date: _____ Wage Rate: _____

Department: _____ Supervisor's Name: _____

Accident Location: _____

Accident Date: _____ Time of Accident: _____ Date Injury Reported: _____

Who was Notified: _____

Witness Names: _____

Name of Doctor or Hospital: _____

Employee returned to work? Yes / No If no, anticipated return date: _____

Describe injury: _____

Description of accident: _____

Did equipment malfunction? Yes / No ; If yes, describe malfunction: _____

Describe damage to equipment or property: _____

As you reviewed the facts, what caused this accident? _____

What action has been or will be taken to prevent recurrence? _____

Additional Comments: _____

Employee Signature: _____ Date: _____

Supervisors Signature: _____ Date: _____