Supervisor’s Report Of Accident

Instructions:  This form must be completed when an employee suffers a work-related illness or injury. The completed form must be forwarded to HRM within 24 hours of an employee’s work-related illness or injury.

Employee involved ___________________________  Dept. where accident occurred _______________________________

Employee’s Regular Dept. _____________________ Equipment employee was working with _______________________________

Occupation _________________________________ Length of time on job where accident occurred _________________________

Date of accident ______________           Time of accident ____________ a.m.  p.m.  Shift ______________________

If an injury occurred, was it treated
[ ] On site  [ ] EMS  [ ] Clinic  [ ] Hospital  [ ] Other (describe) ____________________  [ ] Near miss-no injury

Following treatment the injured employee returned to work:
[ ] Same Day  [ ] Next Shift,  [ ] Lost Time at:  [ ] Previous job  [ ] Modified work

Completely describe accident (who, what, when, where, why)
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Body Part(s) injured __________________________________________________

Describe the nature of the injury (cut, burn, crush, etc.) _______________________________________________________________

Accident Type (slip, pushing, pulling, cooking, adjusting machine, etc.) __________________________________________________

Analyze and then describe the underlying causes of the accident, in your opinion, considering Policies, Procedures, Equipment, Training, and Supervision Practices. (Note employee carelessness is not a cause)
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Analyze and describe the Preventive Measures you recommend to address the underlying causes of the accident, considering Company Policies, Procedures, Equipment, Training, and Supervision Practices. (Note - just telling the injured employee to be more careful, after the accident, is an incomplete supervision practice)
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

_________________________________   _________________       __________________________________    _________________
Supervisor’s Signature             Date                      Employee Signature          Date

Person or position who would be responsible for implementing the above: ________________________________________________

Action(s) or corrective action(s) taken to prevent re-occurrence of the above incident or the like: ______________________________

Date corrective action(s) completed: ________________________   By (Signature of individual): _____________________________