

# Supervisor's Accident Investigaton Report

Work Site/Location		
Injured Employee's Full Name	Regular Job Assignment/Classification	
Date and Time of Accident	Location of Accident (Area/Department)	
Equipment Involved? Evidence Saved? Photographs? YES (Please attach) NO		
Accident reported to:	First Aid? _____ RN 24/7 Called? YES NO	Employee sent to Clinic? YES NO
	Hospital/911 Call? YES NO	
Witnesses? (Names, Work Locations, Phone #'s, etc.)		
Supervisor's description of accident/injury		
Cause of Accident/Injury		
Could this accident have been prevented? Explain.		
What steps have been taken to prevent similar accidents?		
Date of Report	Supervisor's Signature	Title

