



SUPERVISOR ACCIDENT INVESTIGATION

☐ Reporting Only

☐ Treatment

Safety Report # _____

Employee Name: _____ Phone: _____

Employee Address: _____

☐ Injury

☐ Illness

☐ Fatality

Date of Incident: _____ Time of Incident: _____

Location of Accident (Address): _____

Lost Time? ☐ Yes / ☐ No

If yes, provide date/hours: From: _____ To: _____

When was the injury/illness reported to supervisor? _____

Did the employee require medical attention? ☐ Yes / ☐ No

If yes, which provider: _____

Are there any Witnesses? ☐ Yes / ☐ No If yes, provide names of witnesses

Name: _____ Name: _____

Name: _____ Name: _____

Injury Report

Describe the Incident *(What task was being performed? Explanation of how the accident occurred? What body part was injured?)*



Injury Report

Were there any safety violations? ☐ Yes/☐ No If yes, please explain:

Was any defective equipment involved? ☐ Yes/☐ No If yes, please explain:

Action Taken *(Describe any corrective procedures that were taken to prevent similar injuries.)*

Illness Report

What was the employee doing when the illness was first noticed?

What were the symptoms of the illness?

Why does the employee feel the illness is job related?

This report is completed by:

Supervisor Name & Title

Date