SUPERVISOR'S REPORT OF ACCIDENT

Company _____ Mailing Address _____

Division _____ Location _____

Employee's Name _____ Soc Sec No _____ Age _____ Sex _____

First Middle Last

Home Address _____ Occupation _____

Date of Accident _____ Time of Accident ☐ A.M ☐ P.M. Department _____ Regular Work? _____

Describe Injury _____ Fatality? ☐No ☐Yes

How Did Accident Happen? _____

Employment Date _____ How Long On This Job? _____

Machine Or Equipment Involved? _____

Unsafe Acts Performed _____

Unsafe Conditions Present _____

What Should Be Done To Prevent Repetition? _____

Has It Been Done? _____ If Not, Give Reason _____

Name of Physician _____ Address _____

Name of Hospital _____ Address _____

Supervisor's Signature _____ Date _____ Reviewed By _____ Date _____