Supervisor and Employee Report of Accident

Employee Name:_______________ Social Security Number: __________________

Job Title: _____________________ Supervisor: ____________________________

Date of Accident: ______________ Time of Accident: _______________________

Date Accident was Reported: _____ Time of Report:_________________________

Witness Name(s): ____

Type of Accident:

__ No Injury __ First Aid Only __ Medical __ Fatality

Restricted Duty? __ No __ Yes; Number of Days ____

Lost Work Days? __ No __ Yes; Number of Days ____

Date of First Medical Treatment: ______________ Time of Treatment: __________

Name of Medical Provider:___________________ Phone Number: _____________

Address of Medical Provider ____
____

Describe how the accident occurred. ____
____
____

What actions, events or conditions contributed to the accident? ____________________
____
____

What can be done to prevent this type of accident? ______________________________
____
____

____________________________________ ___________________________

Supervisor Signature: Date:

____________________________________ ___________________________

Employee Signature: Date: