



SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Company Name _____ Job Name _____
 Name _____ Sex _____ Age _____ Marital Status _____
 Date of Birth _____ Social Security No _____
 Length of Service _____ Time on Present Job _____
 Job Being Done _____ Was This A Regular Job _____
 Accident Date _____ Time _____
 Accident Location (Specify) _____
 Part of Body Injured _____ Nature of Injury _____
 Describe What Happened _____

What Did Employee Do/Fail To Do That Contributed To Accident _____

What Equipment Was Damaged? _____

Was Accident Result of: * Unsafe Act *Unsafe Practice *Unsafe Condition (Circle One)

What Corrective Action Have You Taken/Plan to Take to Prevent Reoccurrence?

Hours Lost From Work on Day of Accident _____ Rate of Pay _____
 Witnesses _____
 How Long on Job Before Accident Occurred? _____
 Time and Date Reported To Medical _____

Loss Severity Potential: * Major * Serious * Minor
 Probable Reoccurrence Rate * Major * Serious * Minor

Comment Upon Reviewing by Safety Manager _____

Signature of Supervisor _____ Date _____
 Signature of Employee _____ Date _____

This form must be completed by supervisor **within 8 hours** of accident.
 IT IS VERY IMPORTANT that the job name be specified in accident location.