SUPERVISOR'S REPORT OF ACCIDENT

This form should be completed by the supervisor as soon after a work accident as possible. It is useful in gathering information for investigating accidents and their causes so that corrective action can be taken and future accidents avoided. Every accident should be investigated and the causes corrected.

Name of Employee: _____ City/City Organization: _____ Dept.: _____

Date of Accident: _____ Time of Accident: _____ Did employee lose time from work? YES ☐ NO ☐

Hours lost on day of accident: _____ Has employee returned to work? YES ☐ NO ☐

Employee's job title: _____ Years of employee's service with City/City organization: _____

Years employee has been in present job: _____ Number of hours employee works per week: _____

GIVE US YOUR HONEST COMMENTS ON QUESTIONS BELOW. WE ARE NOT TRYING TO BLAME ANYONE. YOUR OPINION MAY HELP US PREVENT ACCIDENT REPETITION.

PLEASE ANSWER THE FOLLOWING: **CHECK "YES" OR "NO"**

1.	HAD INJURED PERSON BEEN PROPERLY INSTRUCTED IN SAFE AND EFFICIENT METHODS? ……	YES ☐	NO ☐
2.	DID INJURED PERSON VIOLATE ANY INSTRUCTIONS? ……..	YES ☐	NO ☐
3.	WAS NECESSARY PROTECTIVE EQUIPMENT WORN? (IF APPLICABLE) ……	YES ☐	NO ☐
4.	DID POOR HOUSEKEEPING CONTRIBUTE TO INJURY? ……..	YES ☐	NO ☐
5.	DID HORSEPLAY CAUSE THE INJURY? ……..	YES ☐	NO ☐
6.	WAS INJURY CAUSED BY SOMETHING THAT NEEDED REPAIRS? ……...	YES ☐	NO ☐
7.	SHOULD A GUARD BE PROVIDED? ……	YES ☐	NO ☐
8.	DID ANY BODILY DEFECT CONTRIBUTE TO INJURY? ……	YES ☐	NO ☐
9.	WAS INJURY CAUSED BY AN UNSAFE ACT? ……	YES ☐	NO ☐
10.	DID INJURED REPORT THE INJURY TO YOU, THE SUPERVISOR, IMMEDIATELY? ……	YES ☐	NO ☐

ACCIDENT. (Describe what the injured employee was doing at the time of the accident, what happened, who was involved, nature of the injury.) _____

_____

_____

Witnesses' Names _____

UNSAFE ACTS. (Did the injured employee or another person do something incorrectly?) _____

_____

_____

_____

UNSAFE CONDITIONS. (What unguarded or unsafe condition of machinery, equipment, building or premises was involved?) _____

_____

_____

ACTIONS TAKEN. (After the injury, what did the employer do to correct the conditions that caused the injury?) _____

_____

_____

REMEDIES. (What should the employer do to prevent other injuries like this?) _____

_____

_____

MEDICAL CARE. Did the employee go to the Doctor or Hospital? YES ☐ NO ☐ If yes, please complete the following:

Name of Doctor or Hospital: _____ Date of initial visit: _____

Address: _____ Telephone number: _____

AS SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS' COMPENSATION? YES ☐ NO ☐

Reasons why or why not: _____

_____

Report Submitted By: _____ Date: _____