SUPERVISOR ACCIDENT INVESTIGATION REPORT

Note: This form must be completed and returned to the Personnel Department within 24 hours.

Insured employee's name _____

Experience in present occupation ____ months/years. Location of incident _____

Did incident arise out of/in the course of employment? Yes ____ No ____

Date/time of incident _____a.m./p.m.

Was employee engaged in regular job duties? Yes ____ No ____

If no, explain _____

_____

Did employee return to work immediately: Yes ____ No ____ If no, explain _____

Did employee seek medical attention: Yes ____ No ____

Name of clinic/hospital _____

For first-aid-only accidents: first aid procedure _____

Administered by: _____ Certification expires _____

Describe the safety training the employee has received in connection with present job duties:

_____

_____

What was employee doing at the time of the incident? (Be specific: name tools or equipment and how they are to be used.) _____

_____

_____

How did the incident occur? _____

_____

_____

Have similar incidents occurred prior to this incident? Yes ____ No ____ If yes, explain: _____

_____

_____

How could this incident have been prevented? _____

_____

_____

What corrective action has been taken? _____

_____

_____

Supervisor's signature _____ Date _____

General Manager's signature _____ Date _____