SUPERVISOR'S REPORT OF ACCIDENT

Company _____ Mailing Address _____

Division _____ Location _____

Employee's Name (First / Middle / Last) | Soc Sec No | Age | Sex

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