

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: _____