SUPERVISOR'S REPORT OF ACCIDENT

Employee's Name:	Age:	Sex:

Job Position/Title:	Social Security Number:

Supervisor's Name:	Shift Hours:	Days off:

Date and Time of Accident:	Location of Accident:

Date and Time Accident Reported:	To Whom:

Task Being Performed When Accident Occurred:

Names of Witness(es):

Accident Resulted in:	( ) Injury	( ) Fatality	( ) Property Damage

First Aid Given:	Medical Treatment Required:	Workdays Lost:
( ) Yes ( ) No	( ) Yes ( ) No	

What Actions, Events or Conditions Contributed Most Directly to the Accident?

Describe How the Accident Occurred:

Signature of Supervisor	Date:

Received in office by:	Date: