

<b>SUPERVISOR'S ACCIDENT INVESTIGATION REPORT</b>			
Company Name:			
Address:			
Telephone Number:			
Name of Injured or Ill Employee:		Employee Address:	
Age:	Sex:	Years of Service:	Time on Present Job
Title/Occupation:		Department/Supervisor:	
Date of Accident	Time of Accident:	Location of Accident:	
Severity of Injury or Illness:			
Non-Disability: Y <input type="checkbox"/> N <input type="checkbox"/>	Disability: Y <input type="checkbox"/> N <input type="checkbox"/>	Medical Treatment: Y <input type="checkbox"/> N <input type="checkbox"/>	Fatality: Y <input type="checkbox"/> N <input type="checkbox"/>
Estimated number of days from job:			
Unsafe mechanical/physical/environmental condition at the time of accident (be specific):			
Unsafe act by injured employee or any other contributing to the accident (be specific):			
Personal factors (attitude, lack of knowledge or skill, slow reaction, fatigue).			
Personal protective equipment required? (protective glasses, safety shoes, safety hat, safety belt)			
What can be done to prevent a recurrence of this type of accident? (modification of machine, mechanical guards, correct environment, training?)			
Detailed narrative description of accident. (How did accident occur?)			
<b>SUPERVISOR'S APPRAISAL AND RECOMMENDATION</b>			
In your opinion, what action on the part of the employee contributed to this accident?			
Recommendation(s):			
Supervisor's Signature:		Date:	