

# 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	DEPARTMENT
	A.M. P.M.	REGULAR WORK?

DESCRIBE INJURY \_\_\_\_\_

FATALITY  NO  YES

HOW DID ACCIDENT HAPPEN? \_\_\_\_\_

MACHINE OR EQUIPMENT INVOLVED?	EMPLOYMENT DATE	HOW LONG ON THIS JOB?
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UNSAFE ACTS PERFORMED \_\_\_\_\_

UNSAFE CONDITIONS PRESENT \_\_\_\_\_

WHAT SHOULD BE DONE TO PREVENT REPETITION? \_\_\_\_\_

HAS IT BEEN DONE?	IF NOT, GIVE REASON
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NAME OF PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_

NAME OF HOSPITAL \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPERVISOR'S SIGNATURE	DATE	REVIEWED BY	DATE
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