SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

work related or on-the-job incident/injury

Send this form to your company's main office, Manager, Risk Manager, or designee within 24 hours.

Employee Name _____

Date of birth: _____ **Sex** _____ **Wage** _____ **SSN** _____

Employee Address _____ **Phone No. (work)** _____ **Phone No. (home)** _____

Department/Shift: _____ Occupation: _____ How Long on Job? _____

Date of work injury _____ **Exact time of injury** _____ **Where did this happen?,**

incl. street address or department/location the employee was in at the time. _____

List witnesses, addresses and phone numbers, including any persons that may have knowledge of the injury or incident, if known.

Name _____ Address _____ Ph.# _____

Name _____ Address _____ Ph.# _____

Name _____ Address _____ Ph.# _____

Did you take the employee to the doctor? Yes _____ No _____

Did the employee go to a doctor on own? Yes _____ No _____

Did the employee lose any work time due to the alleged injury i.e. unable to report to work for the next regular shift? Yes _____ No _____

List attending physician and or Hospital, if known.

Doctor Name _____ Address _____ Ph.# _____

Hospital Name _____ Address _____ Ph.# _____

How long is the employee expected to be off work, if any?

Has the employee returned to work? Yes _____ No _____ (as of date of this report)

A. What Happened? *Describe what took place or what caused you to make this investigation.*

_____

_____

_____

B. Why Did It Happen? *Get all the facts by studying the job and the situation involved. Question by use of WHY, WHAT, WHERE, WHEN, WHO, AND HOW. (Do not use words, like "careless", "not alert" state why such acts or inattention were involved in the first place)*

_____

_____

_____

_____

C. What Should Be Done to prevent repeat of similar incident? (To be completed by the injured employees immediate supervisor .... Manager should suggest any additional action).

Number each action. Determine which items need additional attention (people, equipment, material). Do not use words/phrases like "cautioned" "Told to be careful".

_____

_____

_____

Continued on back

D. What Have You Done Thus Far? *Use the same action numbers as above. Take recommended action, depending on your authority. Follow-up: Was action effective? Insert work order numbers.*

_____

_____ Date _____

_____ Date _____

E. How Will This Improve Operations?

_____

_____

_____

Name of the injured employees immediate supervisor _____ Ph.# _____

Investigated By: _____ Title _____ Date _____ Ph.# _____

Employee signature _____

Name of company nurse, if any _____ Ph.# _____

Reviewing Dept. or Area Manager: _____ Date _____

Date this report was completed _____

Date this report was forwarded to the company manager or front office _____

ACCIDENT REPORT

EMPLOYER: _____ POLICY#_____

DBA:_____

ADDRESS: _____

PHONE#_____ FAX#_____

EMPLOYEE: _____ D.O.B._____ SS# _____

ADDRESS: _____

PHONE#_____ JOB DESCRIPTION: _____

DATE, TIME, & PLACE OF ACCIDENT:_____

DESCRIPTION OF ACCIDENT:_____

_____

DESCRIPTION OF INJURIES: _____

DATE DISABILITY BEGAN:_____ DATE RETURNED TO WORK: _____

AVERAGE GROSS WEEKLY WAGE 12 WEEKS PRIOR TO ACCIDENT: _____

HOURLY RATE: _____

DID INJURED REQUIRE MEDICAL CARE: _____

PHYSICIAN: _____ PHONE: _____

NAME OF HOSPITAL: _____

NAME, ADDRESS & PHONE# OF WITNESS: _____

_____

SIGNED:_____ POSITION: _____ DATE:_____

FPCEWRP