

## SUPERVISOR'S REPORT OF ACCIDENT

This form should be completed by the supervisor as soon after a work accident as possible. It is useful in gathering information for investigating accidents and their causes so that corrective action can be taken and future accidents avoided. Every accident should be investigated and the causes corrected.

Name of Employee: \_\_\_\_\_ City/City Organization: \_\_\_\_\_ Dept.: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ Did employee lose time from work? YES  NO

Hours lost on day of accident: \_\_\_\_\_ Has employee returned to work? YES  NO

Employee's job title: \_\_\_\_\_ Years of employee's service with City/City organization: \_\_\_\_\_

Years employee has been in present job: \_\_\_\_\_ Number of hours employee works per week: \_\_\_\_\_

**GIVE US YOUR HONEST COMMENTS ON QUESTIONS BELOW. WE ARE NOT TRYING TO  
BLAME ANYONE. YOUR OPINION MAY HELP US PREVENT ACCIDENT REPETITION.**

*PLEASE ANSWER THE FOLLOWING:*

**CHECK "YES" OR "NO"**

- |     |  |                              |                             |
|-----|--|------------------------------|-----------------------------|
| 1.  | HAD INJURED PERSON BEEN PROPERLY INSTRUCTED IN SAFE AND EFFICIENT METHODS? ..... | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2.  | DID INJURED PERSON VIOLATE ANY INSTRUCTIONS? .....                               | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 3.  | WAS NECESSARY PROTECTIVE EQUIPMENT WORN? (IF APPLICABLE) .....                   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 4.  | DID POOR HOUSKEEPING CONTRIBUTE TO INJURY? .....                                 | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 5.  | DID HORSEPLAY CAUSE THE INJURY? .....  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 6.  | WAS INJURY CAUSED BY SOMETHING THAT NEEDED REPAIRS? .....                        | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 7.  | SHOULD A GUARD BE PROVIDED? .....  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 8.  | DID ANY BODILY DEFECT CONTRIBUTE TO INJURY? .....                                | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 9.  | WAS INJURY CAUSED BY AN UNSAFE ACT? .....  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 10. | DID INJURED REPORT THE INJURY TO YOU, THE SUPERVISOR, IMMEDIATELY? .....         | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

**ACCIDENT.** (Describe what the injured employee was doing at the time of the accident, what happened, who was involved, nature of the injury.) \_\_\_\_\_

Witnesses' Names \_\_\_\_\_

**UNSAFE ACTS.** (Did the injured employee or another person do something incorrectly?) \_\_\_\_\_

**UNSAFE CONDITIONS.** (What unguarded or unsafe condition of machinery, equipment, building or premises was involved?) \_\_\_\_\_

**ACTIONS TAKEN.** (After the injury, what did the employer do to correct the conditions that caused the injury?) \_\_\_\_\_

**REMEDIES.** (What should the employer do to prevent other injuries like this?) \_\_\_\_\_

**MEDICAL CARE.** Did the employee go to the Doctor or Hospital? YES  NO  If yes, please complete the following:

Name of Doctor or Hospital: \_\_\_\_\_ Date of initial visit: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone number: \_\_\_\_\_

**AS SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS' COMPENSATION?** YES  NO

Reasons why or why not: \_\_\_\_\_

Report Submitted By: \_\_\_\_\_ Date: \_\_\_\_\_