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 ☐ A.M ☐ P.M.		Department Regular Work?		
Describe Injury						
				Fatality? ☐No ☐Yes		
How Did Accident Happen?						
		Employment Date		How Long On This Job?		
Machine Or Equipment Involved?						
Unsafe Acts Performed						
Unsafe Conditions Present						
What Should Be Done To Prevent Repetition?						
Has It Been Done?	If Not, Give Reason					
Name of Physician		Address				
Name of Hospital		Address				
Supervisor's Signature		Date		Reviewed By		Date