# Supervisor’s Report of Accident

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| This form should be completed by the supervisor after a work accident so that corrective action can be taken and future accidents can be avoided. Every accident should be investigated, and the causes corrected. |
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| Employee Information |

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| Employee Name (Last, First, Middle) |  |
| City/City Organization |  |
| Department |  |
| Date of Accident |  |
| Time of Accident |  |
| Did employee return to work? |  |
| Employee’s Job Title |  |
| Years of employee’s service with City/City Organization |  |
| Years employee has been in present job |  |
| Hours worked per week |  |

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| The following questions are not meant to put blame on anyone. Your honest feedback will help prevent accident repetition in the future. |

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| 1. Had injured person been properly instructed in safe and effective methods? |  |
| 2. Did injured person violate any instructions? |  |
| 3. Was necessary protective equipment worn (if applicable)? |  |
| 4. Did poor housekeeping contribute to the injury? |  |
| 5. Did horseplay cause the injury? |  |
| 6. Was injury caused by something that needed repairs? |  |
| 7. Should a guard be provided? |  |
| 8. Did any bodily defect contribute to the injury? |  |
| 9. Was the injury caused by an unsafe act? |  |
| 10. Did the injured person report the injury to their supervisor immediately? |  |

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| Details of Accident | |
| Accident. Describe what the injured employee was doing at the time of the accident, what happened, who was involved, nature of the injury. |  |
| Witness Name: |  |
| 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? |  |

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| **Medical Care.** Did the employee go to the doctor or hospital? (If yes, complete the following questions.) |  |
| Name of Doctor or Hospital |  |
| Date of Initial Visit |  |
| Address (Street, City, State, Zip) |  |
| Telephone Number |  |

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| Workers’ Compensation |

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| As supervisor, do you feel this injury should be covered under workers’ compensation? Include reasons why or why not. |  |

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| Additional Information / Comments |

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| Submission |

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| Report Submitted By |  |
| Date |  |