Supervisor's Accident Report

To be completed by Supervisor of Injured Employee

Claimants Personal Information			
Driver's License Number :	**Social Security Number:**		
Full Legal Name:			
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Gender:**	**M F**
Email Address:	**Date of Birth:**		
Job Position:	**Date of Hire:**		

Incident Information	
Date of Injury:	**Time of Injury:** ◯ **AM** ◯ **PM**
Date Reported:	**Location:**
Accident Description / Summary of Incident	
Initial Medical Treatment: ◯ **None Required** ◯ **Refused** ◯ **First Aid Only** ◯ **Physician/ Treatment Facility Visit** ◯ **Emergency Room Visit**	
Witness Name:	**Phone Number:**
Witness Name:	**Phone Number:**
Describe Injury (include injured body part):	
How did the accident happen:	
Machine or Equipment involved?	
Unsafe Acts Performed?	**Unsafe Conditions Present?**
Corrective Action Taken?	
Employee Signature:	**Date:**
Supervisor Signature:	**Date:**

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