

Sample Supervisor's Accident Investigation Report 207-1

The Supervisor must complete this form with the employee and then forward it to HR within 24 hours after the incident.

Employee Name	Date of Birth	Department	Work Unit	Job Title
Location of Incident	Date of Incident	Time of Incident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Date Incident Reported	
Body Part(s) Injured	Did the employee need medical treatment? <input type="checkbox"/> None <input type="checkbox"/> First Aid <input type="checkbox"/> ER <input type="checkbox"/> Middlesex Occ Health <input type="checkbox"/> Other			
Cause of Injury (slip/fall, MVA, assault):			Type of Injury (bruise, burn, strain):	

Briefly describe the incident:

List other employees involved or witnesses:

Corrective Action Recommendations:

Supervisor's Signature: _____ Print Name: _____ Date: _____

Human Resources Comments & Recommendations: _____ Date Report Received: _____

Call to check on employees status: _____
 Incident sent to Debriefing (Safety) team: _____
 Referred to WC Loss Control Consultant: _____