**SUPERVISOR’S ACCIDENT/INJURY INVESTIGATION REPORT**

***Instructions:*** *Supervisor & employee shall complete the report, attach photographs, applicable documentation and submit to the Human Resources Department*.

Employee Information:

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| --- |
| Employee Name: Employee Phone Number: |
| Employee Address, City, State, Zip Code: |
| Social Security Number: Date of Birth: Sex: |
| Department: Occupation: |
| Date of Hire: Supervisor Name: |

**Incident Information**

|  |
| --- |
| Date of Incident: Time of Incident: [ ]  AM [ ]  PM |
| Date Claim Reported: Name of Representative: |
| Location of Incident: |
| Type of Incident: |
| Description of Incident |

**Vehicle Information (If Applicable):**

|  |
| --- |
| Did the incident involve vehicle damage: \_\_\_ Yes \_\_\_\_\_ No **(If yes, complete below)** |
| Were Police Notified? \_\_\_\_\_Yes \_\_\_\_\_ NO |
| Vehicle Number |
| Vehicle’s Make and Model: Vin Number: |
|  **Tracking Number (PD ONLY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**SUPERVISOR’S ACCIDENT/INJURY INVESTIGATION REPORT**

**Injury/Treatment Information (If applicable):**

|  |
| --- |
| Any Injuries? [ ] Yes [ ] No |
| Initial Treatment Received: [ ] First Aid [ ] Medical [ ] Refused |
| If applicable, did employee received mandatory drug/alcohol screening: [ ] Yes [ ] No |
| Hospital/Treatment Center Name: |
| Part of Body Affected: |
| Describe Treatment Received: |

**Witness Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|

|  |
| --- |
| Were there Witnesses? [ ] Yes [ ] No (If yes, complete below) |
| Witness (1) Name: |
| Witness (1) Phone number: |
| Witness (2) Name: |
| Witness (2) Phone number: |

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**Prevention Information:**

|  |
| --- |
| Do you feel that any process or procedures could be changed to prevent this type of incident from occurring in the future? |
| Were safeguards or safety equipment provided or in place? [ ] Yes [ ]  No |
| Were Safeguards or safety equipment used? [ ]  Yes [ ]  No |

|  |
| --- |
| If yes, please explain: |

**EMPLOYEE’S ACCIDENT/INJURY STATEMENT**

**Incident Information:**

|  |
| --- |
| Please describe in detail the cause of the accident/injury. Include place of the accident and description of injury sustained. What was taking place prior to the accident? What occurred to cause the incident? |
|  |

**Employee’s Signature: Date:**

**Supervisor’s Signature: Date:**

**Department Head’s Signature: Date:**

**Human Resources Director’s Signature: Date:**