# SUPERVISOR'S ACCIDENT INVESTIGATION FORM

This form must be completed every time an employee is injured, regardless if they open a Workers' Compensation claim or refuse medical treatment.

Employee: ______________________________ Supervisor: ______________________________

Dept: ______________________________ Employee's Title: ______________________________

Date Injury Occurred: ______________________________ Time of Injury: ______________________________

Date Injury Reported: ______________________________ Time Injury Reported: ______________________________

How did the injury happen (please explain in detail, using attachments as necessary)?

Describe the injury and part of body affected.

Describe factors about the surroundings that contributed to the injury.

What recommendations do you have to prevent a recurrence (please be specific)?

Have the above recommendations been implemented?  If not, when will implementation take place?

Employee's Signature: ______________________________ Date: ______________

Supervisor's Signature: ______________________________ Date: ______________

Director's Signature: ______________________________ Date: ______________

Submit completed form to the Human Resources department within 48 hours of date of injury.

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