

**SUPERVISOR'S ACCIDENT INVESTIGATION**

**NOTE TO SUPERVISOR:**

Remember, an accident investigation is not designed to find fault or blame. It is an analysis to determine cause that can be controlled or eliminated.

When completing the investigation, try to answer these questions.

- How did the accident occur?
- Where did it happen?
- What materials, machines, equipment or conditions were involved?
- Who was injured?
- When did it happen?

**MAKE RECOMMENDATIONS!**

No investigation is complete unless corrective action is suggested.

**FOLLOW-UP**

Determine what action is being taken on your recommendations.

DATE		TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	
EMPLOYEE INVOLVED		AGE	
POSITION		DATE EMPLOYED	
SUPERVISOR		DEPARTMENT	
HOW LONG WAS EMPLOYEE PERFORMING THIS OPERATION?			
WAS THE EMPLOYEE INSTRUCTED?		DID THE ACCIDENT RESULT IN AN INJURY?	
NATURE AND EXTENT OF INJURY			
DATE INJURY REPORTED		WAS FIRST AID GIVEN?	
IF SO, WHEN AND BY WHOM?			
HOW DID THE ACCIDENT OCCUR?			
CAUSE OF ACCIDENT			
RECOMMENDATIONS TO PREVENT A RECURRENCE			
WHAT ACTION HAS BEEN TAKEN?			
SIGNED		DEPARTMENT	DATE

**SAFETY OFFICIAL OR COMMITTEE COMMENTS**

RECOMMENDATIONS	
SIGNED	DATE

**EXECUTIVE**

SPECIAL ORDERS	
SIGNED	DATE

**ACCIDENT INVESTIGATION REPORT  
EMPLOYEE DESCRIPTION**

<b>NAME</b>		<b>DEPARTMENT</b>		<b>DATE</b>
<b>SEX</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<b>OCCUPATION</b>		<b>SUPERVISOR</b>
<b>DATE OF INJURY</b>	<b>TIME</b> <input type="checkbox"/> AM <input type="checkbox"/> PM	<b>DATE FIRST REPORTED</b>	<b>TIME</b> <input type="checkbox"/> AM <input type="checkbox"/> PM	
<b>NATURE OF INJURY</b>				
<b>PART OF THE BODY</b>				
<b>LOCATION OF ACCIDENT</b>				
<b>INJURED'S DESCRIPTION OF ACCIDENT</b>				

I do \_\_\_ do not \_\_\_ feel that this injury will result in lost time from work. Please read the following paragraph:

If an injury requires lost time from work or you need to be seen by a physician, you must clear this with your supervisor. For all medical treatment, other than an emergency, a Medical Authorization for Treatment form must be picked-up from: \_\_\_\_\_ and presented to the approved treating facility. A failure to present this form at the treating facility means the company has not authorized the treatment and our insurance will not pay. Please sign below to indicate you have read the above and understand its meaning in full.

Signed: \_\_\_\_\_  
Employee
Witness

Employee Sent:     Back to Work    Doctor    Hospital    Home

Have employees complete this report as well as the First Report of Injury.

Supervisor's Investigation on the reverse must be completed within 24 hours after notification of accident.