

**SUPERVISOR'S ACCIDENT INVESTIGATION**

**(NOT a First Report of Injury Form)\*Please use your state appropriate form to report an injury**

**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<br><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  
(Employee To Fill Out This Page)**

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

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

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

# WITNESS ACCIDENT REPORT

Return to : <A href="mailto:fbw@cg7chlfc">fbw@cg7chlfc` within 2 days of accident

You have been listed as a witness to an injury experienced by \_\_\_\_\_ that occurred on \_\_\_\_\_, 20\_\_\_\_. To assist FHM Insurance in investigating this incident, please complete and return this form to the loss control representative at the address below. This is not a sworn statement.

Witness Information- Job Title: \_\_\_\_\_ Dept.: \_\_\_\_\_  
Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Ext.: \_\_\_\_\_ SSSS  
Address: \_\_\_\_\_

## Incident Information

Did you witness the personal injury involving the above named person (please check)? \_\_\_\_\_ yes \_\_\_\_\_ no

Location of the incident (be specific): \_\_\_\_\_

Approximate time of the incident: \_\_\_\_\_ Date of the Incident: \_\_\_\_\_

Describe what you witnessed concerning this incident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide the names of other known witnesses to this incident: \_\_\_\_\_

\_\_\_\_\_

What suggestions do you have to prevent this incident from happening again? \_\_\_\_\_

\_\_\_\_\_

Have you reported this problem to any other departments ?

\_\_\_\_\_



Please Return this Form to:  
FHM Loss Control Dept.  
P.O. Box 616648  
Orlando, FL 32861  
888-346-3461