

Accident / Injury Report

Supervisor's Report

(To be filled out **immediately** for all occupational injuries or illnesses)

Supervisors Name: _____

Date & Time incident was reported to you: _____

Describe the accident: _____

Was first aid required? If yes, describe what was performed. _____

Was doctor's attention required? _____

What were the causes of this incident? _____

What part of the body was injured? Be detailed. _____

Other pertinent details of the incident: _____

Supervisor's Signature: _____ **Date:** _____