

## Supervisor's Accident Investigation Report

Investigate ALL ACCIDENTS: Help Stop accidents by discovering how and why this one happened. Determine and correct the basic cause of this accident in your department and help to prevent accidents in the future. Please type or print the information requested below and return to the EHS&RM Office within 24 hours if the accident

Name: \_\_\_\_\_ Employee ID No: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Telephone # \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(Number & Street) (City or Town) (State) (Zip)

Marital Status: \_\_\_\_\_ Married: \_\_\_\_\_ Single: \_\_\_\_\_ Widow: \_\_\_\_\_ Divorced: \_\_\_\_\_

Employment Date: \_\_\_\_\_ Class Title: \_\_\_\_\_ Dept.: \_\_\_\_\_

Shift Starts: A.M. \_\_\_\_\_ P.M. \_\_\_\_\_ Shift Ends: A.M. \_\_\_\_\_ P.M. \_\_\_\_\_

Type of Employee: \_\_\_\_\_ Faculty: \_\_\_\_\_ Part Time Faculty: \_\_\_\_\_ Classified: \_\_\_\_\_

Hourly/Wage Employee: \_\_\_\_\_ Student Worker: \_\_\_\_\_ Temp.: \_\_\_\_\_

### **OCCUPATIONAL INJURY OR OCCUPATIONAL ILLNESS**

Date Accident Occurred: \_\_\_\_\_ Time: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Date Reported to Supervisor: \_\_\_\_\_ Time: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Where did Accident Occur: \_\_\_\_\_  
(Building) (Room)

Brief description of how the accident occurred (Be specific and name any object or substances involved and state what the employee was doing when injured).

Exact location of injury (Indicate the part of body affected; e.g. right or left, upper or lower, index finger, etc.).

Did injured visit physician? \_\_\_\_\_ Yes \_\_\_\_\_ No

Name and Address of physician? \_\_\_\_\_

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Name and Address of Hospital: \_\_\_\_\_

Name of Health Insurance Plan: \_\_\_\_\_

Name and Address of Witnesses: \_\_\_\_\_

What should be done to prevent repetition?: \_\_\_\_\_

Has it been done: \_\_\_\_\_ Yes \_\_\_\_\_ No If not, give reason: \_\_\_\_\_

Was employee instructed regarding hazards on job?: Yes \_\_\_\_\_ No \_\_\_\_\_

Lost Time: \_\_\_\_\_ Yes \_\_\_\_\_ No Probable length of disability: \_\_\_\_\_

Has injured returned to work?: \_\_\_\_\_ If so, date and hour: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's Comments: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***The supervisor is responsible for informing Risk Management when the employee returns to work (757)823-9142***

**NOTE:** In order to complete the report thoroughly, it is suggested that the employee and supervisor complete it together.

### **DO NOT WRITE BELOW THIS LINE. RISK MANAGEMENT OFFICE USE ONLY**

Date Received: \_\_\_\_\_ Length of Disability: \_\_\_\_\_ From \_\_\_\_\_ TO \_\_\_\_\_

Date of follow-up: \_\_\_\_\_ Number of days lost: \_\_\_\_\_

Comments: \_\_\_\_\_

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