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: _____ SSN No: 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: _____