SUPERVISOR’S REPORT of ACCIDENT
(To be filled out for all occupation injuries)

Supervisor’s Name:  

Date:  Exact time reported to you:  
Injuried employee’s name:  
Who reported it:  
Name(s) of witness(es):  

Describe the accident:  

Was first aid required?  

Did the accident require a doctor’s treatment?  

Date and time of next doctor’s appointment:  

EXPLAIN IN DETAIL: What part of the body was injured?  BE SPECIFIC  

Other details of the accident:  

Supervisor’s Signature:  Date:  

This form is to be returned to your supervisor as soon as possible.

Date office received report:  

Employees should make a prompt report to their immediate supervisor of each industrial injury or occupational illness, regardless of the degree of severity.