

This form must be completed thoroughly by employee's supervisor within 24 hours after an accident

PART I – GENERAL INFORMATION

Employee Name		Title		Social Security No.
Address		City/State	Zip	Home Phone
Agency		Location		Work Phone
Job Description and/or Assigned Duties of Employee (be specific):				
Number of Years in current job title: _____				
Previous job title: _____ Number of years previous title: _____				
Activity at time of accident/incident: _____				
Date of Accident/Incident	Hour:	<input type="checkbox"/> AM <input type="checkbox"/> PM	Exact Location	
Did you witness? <input type="checkbox"/> Yes <input type="checkbox"/> No	How was notice received? <input type="checkbox"/> Written <input type="checkbox"/> Oral	Date Received	Time Received	From Whom Notice Received

PART II – DETAILS OF ACCIDENT

Description of Accident/Incident:				
Did a third party cause or contribute to the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, explain and provide name, address and phone number of negligent party (use reverse side if necessary):				
Description of Injury – Part(s) of Body Injured:				
Name(s) of Witness(es) (if none, so state):				

PART III – CAUSE OF ACCIDENT

Describe any unsafe acts or conditions which contribute to the accident/incident:				
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PART IV – CORRECTIVE ACTION TAKEN

Was the condition above corrected (how)?	Reported to higher authority (Name & Title)?
Name and Title of Supervisor	Did the incident result in any disciplinary action? <input type="checkbox"/> Yes <input type="checkbox"/> No

 Signature of Supervisor/Phone Number

 Report Date