SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

GENERAL INFORMATION	DEPARTMENT		SHIFT
	EMPLOYEE NAME		JOB TITLE
	EMPLOYEE NUMBER		SEX (M/F)
	TYPE OF ACCIDENT/ILLNESS		
	TYPE OF INJURY		
	PART OF BODY INJURED	TREATMENT ☐ FIRST AID ☐ MEDICAL	DID EMPLOYEE RETURN TO WORK THE SAME DAY? ☐ YES ☐ NO
DESCRIPTION	WHERE DID THE ACCIDENT HAPPEN? USE ADDITIONAL SHEETS IF NECESSARY		
CAUSES	SPECIFIC MACHINE, TOOL, SUBSTATNCE OR OBJECT CONNECTED WITH THE ACCIDENT		
	UNSAFE MECHANICAL/PHYSICAL/ENVIRONMENTAL CONDITION AT TIME OF ACCIDENT (Be Specific)		
	PERSONAL FACTORS (Attitude, Lack of Knowledge or Skill, Slow Reaction, Fatigue)		
	PERSONAL PROTECTIVE EQUIPMENT REQUIRED		
	WAS INJURED EMPLOYEE USING REQUIRED EQUIPMENT?		
RECOMMENDATIONS	ACTION PLAN TO PREVENT RECURRENCE (Modification of Machine, Mechanical Guarding, Environment, Training) _____ SUPERVISOR'S SIGNATURE _____ DATE		
FOLLOW-UP	ACTIONS TAKEN ON RECOMMENDATIONS (Include Date Completed)		