

SUPERVISOR'S REPORT OF ACCIDENT

N In order to prevent accidents, it is necessary to know how and why they occur. State facts as accurately as possible. Accurate reporting of all
O facts will help in the preparation of the "Employer's Report." Submit you complete report within 24 hours. If additional space is needed, use
T reverse side.
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Name of Injured Employee		Department in Which Regularly Employed	
Injury Date	Time	a.m. p.m.	Date Employer was Notified of Injury
Did Accident Occur on Employer's Premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where? (Specify dept., job site, etc.)	Name of witnesses
What was employee doing when injured? (Such as: walking, lifting, operating machines, etc.) Be specific			
Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. (Do not describe nature of injury)			
What machine tool, substance or object was most closely connected with the injury? (e.g., the machine employee struck against or which struck him; the chemical that irritated his skin; in cases of strain, the thing he was lifting, pulling, etc.)			
Nature of Injury and part of body affected.			
CAUSES OF ACCIDENT: CHECK ALL THAT APPLY			
UNSAFE BUILDING OR WORKING CONDITIONS <input type="checkbox"/> LAYOUT OF OPERATIONS <input type="checkbox"/> LAYOUT OF MACHINERY <input type="checkbox"/> UNSAFE PROCESSES <input type="checkbox"/> IMPROPER VENTILATION <input type="checkbox"/> IMPROPER SANITATION/HYGIENE <input type="checkbox"/> IMPROPER LIGHT <input type="checkbox"/> EXCESSIVE NOISE <input type="checkbox"/> FLOORS OF PLATFORMS <input type="checkbox"/> MISCELLANEOUS HOUSEKEEPING <input type="checkbox"/> IMPROPERLY PILED OR STORED MATERIAL <input type="checkbox"/> CONGESTION PHYSICAL HAZARDS OR EQUIPMENT <input type="checkbox"/> INEFFECTIVELY GUARDED <input type="checkbox"/> UNGUARDED <input type="checkbox"/> GUARD REMOVED <input type="checkbox"/> DEFECTIVE TOOLS <input type="checkbox"/> DEFECTIVE MACHINES <input type="checkbox"/> DEFECTIVE MATERIALS		INSTRUCTIONS AND TRAINING <input type="checkbox"/> NONE <input type="checkbox"/> INCOMPLETE <input type="checkbox"/> ERRONEOUS <input type="checkbox"/> NOT FOLLOWING INSTRUCTIONS <input type="checkbox"/> OPERATING WITHOUT AUTHORITY <input type="checkbox"/> WORKING AT UNSAFE SPEED <input type="checkbox"/> INEXPERIENCE <input type="checkbox"/> UNTRAINED IN PROCEDURE <input type="checkbox"/> INCORRECT USE OF TOOL OR EQUIPEMENT <input type="checkbox"/> IMPROPER JUDGMENT <input type="checkbox"/> IMPROPER LIFTING <input type="checkbox"/> LIFTING EXCESSIVE WEIGHT DISCIPLINE <input type="checkbox"/> NOT FOLLOWING SAFETY RULES <input type="checkbox"/> HORSEPLAY APPAREL OR PERSONAL PROTECTIVE EQUIPMENT <input type="checkbox"/> PROTECTIVE EQUIPMENT NOT USED <input type="checkbox"/> UNSUITABLE PROTECTIVE EQUIPMENT <input type="checkbox"/> UNSUITABLE CLOTHING OR FOOTWEAR	
What can be done to prevent such an accident from happening again?			
Approx. date condition will be corrected?		Signature of Supervisor:	
		Date:	

