Supervisor's Accident Investigation Report

To be completed by the Supervisor and forwarded to Human Resources within 24 hours of the incident. Phone: (973) 596- 5553 / Fax: (973) 642-4066

Name of Injured: ____ EID #:__________________

Job Title: ____ Department: ________________________

Length of experience on the job: _____ (years) ____ (months) Work Phone #:________________

Date of Accident: _______________________________ Time of Accident: _______________________

Accident Location: ____

Injury Type: ______ First Aid (no medical treatment) ______ Medical (Medical treatment required)

If medical treatment is required, where was the medical treatment sought? __________________________

Describe the accident and how it
occurred:____
____
____
____
____

Describe the injury and part of body affected (sprain, cut, burn, right, left, arm/foot, etc.)
____
____

Cause of the accident:____

____
____

Was Personal Protective Equipment required? ____ Yes ____ No Was it provided? ____ Yes ____ No

Was PPE being used? ____Yes ____ No If "No" explain:____________________________________

Was safety training provided to the injured employee? ____Yes ____No

Corrective actions taken to prevent recurrence: ____

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Supervisor Name (Print):________________________________ Telephone #:______________________________

Supervisor Signature: ___________________________________ Date: __________________________________