



Supervisor's Accident Investigation Form

Name of Injured Employee _____

Date of Event _____ Time of Event _____

Exact location of event: _____

What part of employee's workday?

- | | |
|---|---|
| <input type="checkbox"/> Entering or leaving work | <input type="checkbox"/> Doing normal work activities |
| <input type="checkbox"/> During meal period | <input type="checkbox"/> During break |
| <input type="checkbox"/> Working overtime | <input type="checkbox"/> Other |

Describe fully how the accident happened? What was employee doing prior to the event? What equipment, tools being using?

What caused the event?

Were safety regulations in place and used? If not, what was wrong?

Recommended preventive action to take in the future to prevent reoccurrence.

Supervisor Signature

Date