



Supervisor's Report of Accident Form

Instructions: Supervisors shall use this form to report all work-related accidents/injuries – no matter how minor. This form shall be completed by supervisors with the assistance of the impacted employee as soon as possible. All completed forms should be sent to Human Resources.

The entire form must be completed prior to submission to Human Resources

Employee name: _____

Date of accident: _____ Time of accident: _____ am pm Shift: _____

Dept. where accident occurred: _____ Employee's regular dept.: _____

Machine # or equipment employee was working with: _____

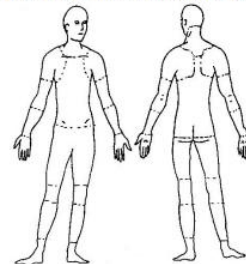
Occupation: _____ Length of time on job when accident occurred: _____

Was this a near/no miss injury? No Yes

If an injury occurred, was it treated: On-site EMS Clinic Hospital Other (describe) _____

Completely describe the accident (who, what, when, where, why):

Part of body affected: (shade all that apply)



For the three statements below, please refer to page 2 to answer.

Body part(s) injured: _____

Nature of injury: _____ Accident type (see page 2): _____

Analyze and then describe the underlying causes of the accident, in your opinion, considering policies, procedures, equipment, training, and supervision practices (Note employee carelessness is not a cause): _____

Analyze and describe the Preventative Measures you recommend to address the underlying causes of the accident, considering company policies and procedures, equipment, training and supervision practices (Note, just telling the injured employee to be more careful after the accident is an incomplete supervision practice): _____

If the employee declined to seek medical treatment the day of the accident, it is understood that the employee has seven (7) days after the accident to seek treatment. Should the employee seek medical treatment for this injury after seven (7) days have lapsed, the employee acknowledges that the district is not liable for any cost associated with medical treatment, paid time off, or loss of pay. _____ Employee Initials

Supervisor's signature: _____ Date: _____

Employee's signature: _____ Date: _____

Action(s) or corrective action(s) taken to prevent reoccurrence of the above incident or the like: _____

Date corrective action(s) completed: _____ By: _____

+Reference Information

Policy: Refer to Chippewa Valley Policy.
Example: eye protection will be worn when necessary.

Procedure: Who is responsible for, and how, the policies are to be carried out.
Example: the supervisor will see that safety glasses are worn when necessary.

Supervision: What and how the Supervisor’s responsibilities are for enforcing the policies and procedures.
Example:
1. Determine if the task requires eye protection, and
2. If it does, will assign safety glasses to each employee, and
3. Will check to see if everyone puts them on, and
4. Continues to wear them.

Equipment: Could also include tools, personal protective equipment, the work area, the product, and containers.
Example: Properly fitting Safety Glasses in good condition.

Body Part: Pick one, then copy it on page 1 of the form.

Upper Back	Lower Back	Head	Ear	Eye	Face
Finger/Thumb	Hand	Wrist	Arm	Shoulder	Internal Organ
Foot	Knee	Leg	Groin/Pelvic	Other (describe)	

Nature of Injury: Pick one, then copy it on page 1 of the form.

Strain/Sprain	Cut/Laceration	Puncture	Bruise/Contusion	Inflammation	Fracture
Repetitive Motion	Dermatitis/Rash	Eye Struck by	Burn	Shock	Crush
Amputation	Hernia	Other (describe)			

Accident Type: Pick one, then copy it on page 1 of the form.

Assembly Operations	Lifting/Lowering	Pushing/Pulling	Other Manual Material Handling	Operating Machine	Adjusting Machine
Repetitive Work	Vehicle Related	Office Work	Using Hand Tools	Slip/Fall Same Level	Slip/Fall from Heights
Painting	Buffing/Grinding	Construction Operations	Cooking	Welding/Burning	Agricultural
Other (describe)					

Miscellaneous comments: _____

