



Supervisor's Accident Investigation

WC Supervisor's Accident Investigation Form

*To be completed by the employee's supervisor or other responsible administrative official

Location where accident occurred?	Employer's Premises: <input type="checkbox"/> Yes <input type="checkbox"/> No Job Site: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of accident or illness:
Who was injured?	<input type="checkbox"/> Employee <input type="checkbox"/> Non-Employee	Time of Accident: <input type="checkbox"/> A.M <input type="checkbox"/> P.M
Length of time with GVRA?	Job Title:	Name of Department:
How long has the employee worked at job where injury or illness occurred?	What property/equipment was damaged?	Property/equipment owned by:
What was employee doing when injury/illness occurred? What machine or tool was being used? What type of operation?		
How did injury/illness occur? List all objects involved.		
Part of body affected/injured?	Any prior physical conditions? If so, what? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nature and extent of injury/illness and property damaged (be specific)		
PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS		
<input type="checkbox"/> Failure to lockout	<input type="checkbox"/> Improper dress	<input type="checkbox"/> Poor housekeeping
<input type="checkbox"/> Failure to secure	<input type="checkbox"/> Improper maintenance	<input type="checkbox"/> Poor Ventilation
<input type="checkbox"/> Unsafe Position	<input type="checkbox"/> Improper guarding	<input type="checkbox"/> Horseplay
<input type="checkbox"/> Unsafe equipment	<input type="checkbox"/> Improper instruction	<input type="checkbox"/> Operating without authority
<input type="checkbox"/> Unsafe arrangement or process	<input type="checkbox"/> Improper protective equipment	<input type="checkbox"/> Inoperative safety device
<input type="checkbox"/> Lack of skill or training	<input type="checkbox"/> Physical or mental impairment	<input type="checkbox"/> Other
Supervisor's Corrective action to ensure this type of accident does not recur:		
Was the employee trained in the appropriate use of personal protective equipment/proper safety procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was employee cautioned for failure to use personal protective equipment/proper safety procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did the employee promptly report the injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is there a modified duty available? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Supervisor's Name: _____

Phone: _____

Supervisor's Signature: _____

Date: _____