



# SUPERVISOR'S INCIDENT REPORT

*This report should be completed for accidents that do not require completion of the Supervisor's Accident Report*

<b>NAME OF EMPLOYEE:</b>	<b>DATE OF ACCIDENT:</b>	<b>TIME OF ACCIDENT:</b>
<b>LOCATION OF ACCIDENT:</b>	<b>EXPERIENCE:</b>	<b>AGE:</b>
<b>DEPARTMENT:</b>	<b>NAME OF SUPERVISOR:</b>	
<b>WHAT HAPPENED?</b> _____		
<b>WHO WAS INJURED AND/OR WHAT EQUIPMENT DAMAGED?</b> _____		
<b>IF DAMAGED PROPERTY, WHO DID IT BELONG TO?</b> _____		
<b>WHAT OTHER CONTROL MEASURES CAN BE TAKEN AND BY WHOM?</b> _____		
<b>BASIC CAUSE</b>		
Unsafe Working Conditions? <input type="checkbox"/>	Wrong Method? <input type="checkbox"/>	
Unsafe Practice? <input type="checkbox"/>	Personal Physical Condition? <input type="checkbox"/>	
Lack of Knowledge or Training? <input type="checkbox"/>	Other: <input type="checkbox"/>	
_____ <b>INJURED EMPLOYEE'S SIGNATURE</b>		_____ <b>DATE</b>
_____ <b>SUPERVISOR'S SIGNATURE</b>		_____ <b>DATE</b>
<b>REPORT DISTRIBUTION:</b> _____		