**Supervisor’s Accident Investigation Report for Employee Injury**

*(To Be Completed by Supervisor of Injured Employee)*

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| **District** | | **Address** | |
| **Name of Injured Employee** | **Dept.** | **Position** | **How long in position?** |
| **Date of Accident** | **Time of Accident** | **Nature of Injury** | |
| **Injury Resulted in: ⁯**Injury ⁯Fatality ⁯Property Damage (specify) | | | |
| **Medical Treatment**  **⁯**None ⁯First Aid ⁯EMT or Paramedic ⁯Doctor or Clinic ⁯Hospital | | | **Days Lost Time?** |
| **What was the injured employee doing at the time of the accident?** | | | |
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| **How did the accident occur (brief description)?** | | | |
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| **What environmental factors (unsafe conditions) contributed to the accident?** | | | |
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| **What behavioral factors (unsafe acts) contributed to the accident?** | | | |
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| **What corrective actions can be taken to prevent recurrence?** | | | |
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| **What corrective action has been taken to prevent recurrence?** | | | |
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| **Names & Phone Numbers of Witnesses** | | | |
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| **Supervisor** | **Date** | **Reviewed by:** | **Date** |

**Original: Business Manager**

**This form must be printed on yellow paper**