



SUPERVISOR ACCIDENT INVESTIGATION REPORT FORM

FORM XXXX

This sample report form is provided to you as a courtesy. You are free to modify this form for your own use as you see fit. Replace the logo in the header with your own logo and add/remove form elements to meet your requirements.

If you are not the end user of this template you are welcome to share this template with others. All we ask is that you keep the following links in this document intact. If you are the end user feel free to remove them.

If you find this template useful please consider taking a look at our line of customized [safety scoreboards](#) to help you automatically track the number of days since a lost time accident or incident. You can also find more great [resources](#) like this one on our blog.

Form Instructions

This form should be completed by the supervisor named in an accident report form and submitted to **[ROLE NAME]** within **[TIMEFRAME]** of any accident/incident reported.

This form serves to document the details of an accident/incident as well as details about possible work hazards that led to the incident.

Accident/Incident Report

First Name (who is completing this report)	Last Name
Position (supervisor from accident report)	Accident Report Number (from accident report)
Work-Related Injury?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Workers Compensation Form Filed?	Details (when was the form filed/id number)
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Government/Insurance Entities Advised (list those advised or enter not applicable)	Date (when were listed entities advised)
Did the injured employee go home during their work shift?	Details (when did they leave the job, etc)
<input type="checkbox"/> Yes <input type="checkbox"/> No	



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Accident Details

How did the accident happen

Additional Witness Details

Contributing Factors (place X where applicable)

<input type="checkbox"/>	Ineffective Guarding	<input type="checkbox"/>	Lack of protective equipment	<input type="checkbox"/>	Lack of training	<input type="checkbox"/>	Lack of maintenance
<input type="checkbox"/>	Safety rules not followed	<input type="checkbox"/>	Inexperience	<input type="checkbox"/>	Unsafe work methods	<input type="checkbox"/>	Misconduct
<input type="checkbox"/>	Workplace design	<input type="checkbox"/>	Weather	<input type="checkbox"/>	Poor Housekeeping	<input type="checkbox"/>	Language Barriers
<input type="checkbox"/>	Other	Comments:					

Explain what caused the accident

Have unsafe conditions been corrected?

Yes

No

Details

(what was done, what needs to be done)

How can a reoccurrence be prevented?



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Additional Comments

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Supervisor Name	Supervisor Signature	Statement Date (Date/Time)