



Supervisor's Incident Report for Non-Industrial Events

This documentation must be completed and submitted to Safety Department within 6 hours of being reported.

INJURED EMPLOYEE						Employee No.			
Job Title									
Accident Location									
Injury Date		Time		AM <input type="checkbox"/> PM <input type="checkbox"/>		Date Responded		Last Day Worked	
Name & Address of Doctor/Hospital									
Did employee return to work?		Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, describe (use reverse if nec.)					
Describe injury or alleged injury									
Description of accident									
Witness									
Did equipment malfunction?		Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, describe (use reverse if nec.)					
Describe damage to equipment or property									
What caused the accident?									
What action has been or will be taken to prevent reoccurrence?									
Remarks									

Supervisor and department: _____

Date: _____