SUPERVISOR INCIDENT REPORT

Company Name _____ Date _____

Associate Name _____ Date of Hire _____

Incident Location (*in facility*) _____

First Aid Administered by _____ ☐ *First Aid Refused*

What Treatment was Administered? _____

Employee was referred for further immediate treatment ☐ *Yes* ☐ *No*

Health Care Facility/Hospital _____ Date _____

INCIDENT DETAILS

Incident Date _____ Time _____ ☐ *AM* ☐ *PM*

Incident Location (*be specific*) _____

Description of Occurance _____

_____

What was the Associate doing when the Incident happened? How did it happen? _____

_____

Describe the injury *(example: sprained left ankle, cut right forearm, burn left ring finger, etc.)* _____

_____

Were there witnesses to the incident? ☐ *Yes* ☐ *No* *(please name)* _____

_____

What Personal Protective Equipment (PPE) were used? _____

_____

Were any safety rules violated? ☐ *Yes* ☐ *No* *If Yes, please explain* _____

_____

I swear that the above statement in regards to the incident and its surrounding events is true to the best of my knowledge.

Print Name _____ Position _____

Signature _____ Date _____