



This form must be completed thoroughly by employee's supervisor within 24-hours after an accident

PART I - GENERAL INFORMATION				
Employee Name	Title		Soc. Sec. No.	
Address	City / State	Zip	Home Phone	
Agency	Location		Work Phone	
Job Description and/or Assigned Duties of Employee: (Be Specific)				
Number of Years in current job title: _____				
Previous job title: _____ Number of years previous title: _____				
Activity at time of accident / incident: _____				
Was said activity within the course and scope of employment or assigned duties <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Accident / Incident	Hour:	A.M. P.M.	Exact Location
Did you witness? <input type="checkbox"/> Yes <input type="checkbox"/> No	How was notice received? <input type="checkbox"/> Written <input type="checkbox"/> Oral	Date Received	Time Received	From Whom Notice Received
PART II - DETAILS OF ACCIDENT				
Description of Accident / Incident:				
Did a negligent third party cause or contribute to the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, explain and provide name, address, and phone number of negligent party (Use reverse side if necessary):				
Description of Injury - Part(s) of Body Injured:				
Name(s) of Witness(es) (if none, so state):				
PART III - CAUSE OF ACCIDENT				
Describe any unsafe acts or conditions which contribute to the accident / incident:				
PART IV - CORRECTIVE ACTION TAKEN				
Was the condition above corrected (how)?		Reported to higher authority (Name & Title)?		
Name and Title of Supervisor		Did the incident result in any disciplinary action? <input type="checkbox"/> Yes <input type="checkbox"/> No		