

**BEAVER COUNTY
SUPERVISOR'S REPORT OF EMPLOYEE INJURY OR ACCIDENT**

Employee name _____ Department _____

Location of incident _____

Date of incident _____ Time _____

Date reported _____

What shift was employee working? _____

To whom was incident reported? _____

Description of injury _____

Part(s) of body injured _____

Name of witness _____

Was there equipment involved? _____

If so, please explain _____

Was accident caused by an unsafe act? _____

If so, please explain _____

Was accident caused by an unsafe condition? _____

If so, please explain _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

What could management have done to prevent the incident? _____

What could employee have done to prevent the incident? _____

Does injury concur with employee's report? _____

Was medical or emergency treatment necessary? Yes _____ No _____

Type of medical treatment provided (doctor, first aid, ambulance to hospital) __

Attending physician (name and address) _____

Lost time from work (estimated)

Days _____ Hours _____ None _____

Any additional information _____

*Prepared by _____ Title _____

*Supervisor's signature is verification that the validity and completeness of the above statements have been checked.

Date _____