

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

CAPP ELECTRIC

Supervisor's Accident Investigation Report

Capp Electric Company

DATE OF THIS REPORT: _____
SUPERVISOR'S NAME COMPLETING REPORT: _____
EMPLOYEE INVOLVED IN ACCIDENT: _____
POSITION EMPLOYED AT TIME OF ACCIDENT: _____
DATE & TIME OF INJURY: _____
DATE INJURY WAS REPORTED TO SUPERVISOR: _____
DATE REPORTED TO OFFICE: _____
NATURE OF INJURY: _____

DID EMPLOYEE RECEIVE MEDICAL ATTENTION: _____
IF SO, WHEN? _____
WHERE? _____
IF NOT WHY? _____

DID EMPLOYEE MISS ANY WORK DUE TO INJURY? _____
IF SO HOW MUCH AND WHEN? _____

HOW DID ACCIDENT OCCUR? _____

DID ACCIDENT RESULT IN UNSAFE PRACTICE BY EMPLOYEE? _____
CO-WORKERS? _____ UNSAFE JOB CONDITIONS? _____
EXPLAIN: _____

HAD UNSAFE JOB CONDITIONS BEEN REPORTED PRIOR TO THE ACCIDENT TO THE
GENERAL CONTRACTOR OR OWNER? _____
THE MAIN OFFICE? _____
IF SO, BY WHOM? _____
REPORTED TO WHOM AND WHEN? _____
WAS ANY ACTION TAKEN? _____

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WAS EMPLOYEE PERFORMING DUTIES ASSIGNED TO HIM/HER AT TIME ACCIDENT OCCURRED? _____

WAS EMPLOYEE IN ASSIGNED WORK AREA AT TIME ACCIDENT OCCURRED? _____

IF NOT, EXPLAIN: _____

NAME OF ANY WITNESSES TO ACCIDENT: _____

NAME OF ANY CO-WORKERS WITH INJURED EMPLOYEE'S CREW AT TIME WHEN ACCIDENT OCCURRED?

WERE THERE ANY CERTAIN MATERIALS, TOOLS, EQUIPMENT OR SPECIFIC CONDITIONS CONTRIBUTING

TO THIS ACCIDENT? _____

RECOMMENDATIONS TO PREVENT REOCCURRENCE: _____

WHAT ACTIONS HAVE BEEN TAKEN? _____

(SIGNATURE OF SUPERVISOR)

ADDITIONAL COMMENTS BY MAIN OFFICE: _____

SIGNATURE