JUNIATA COLLEGE

SUPERVISOR INVESTIGATION OF WORK-RELATED INJURY OR ACCIDENT

This form should be completed by all **supervisors** whenever an employee experiences an accident or injury.

Date of Injury:_____ Location of Injury/Accident:_____

Employee's Name:_____Department:_____

Date & Time Employer Notified_____

Describe the accident:

_____

_____

_____

What was the cause of the accident (Unsafe Act vs. Unsafe Condition)?

_____

_____

_____

What steps will be taken to prevent similar accidents? _____

_____

_____

_____

Did you personally witness this accident or injury?_____

Witnesses: _____

_____

Witnesses' Account: _____

_____

_____

Signature of Supervisor: _____Date: _____

*See reverse side for additional information/comments

Additional comments: _____

_____

_____

_____

_____

_____

_____

Please complete this form within 24 hours after an accident or injury and return to Human Resources with First Report of Injury/Notice of Rights & Duties forms.

Shaded area to be completed by Safety Committee.

Action taken:_____

_____

_____

_____

Signature:_____Date:_____

Notified Supervisor:_____