Supervisor's Report of Accident

This report must be completed within 24 hours by the supervisor and forwarded to the Human Resources. All accidents or occupational diseases involving medical treatment or time loss from work must be reported to the Idaho Industrial Commission and the workers compensation Third Party Administrator in a timely manner. **Employee is responsible to update their supervisor about changes in Work Status.**

Employee Name:_____________________________________ Telephone:____________________ DOB:____________

Department:____ Job Title:______________________

Employee Status: ☐Full Time ☐Part Time ☐Seasonal ☐Volunteer ☐Other

Date of Accident:__________________ Time of Accident:___________ On Employer Premise: ☐Yes ☐No

Exact location where accident occurred:____

Date employer notified:_____________________ Time employer notified:_____________________

Description of Accident (fully describe what was employee doing; how he/she was doing it; and any physical objects involved including weights of materials handled, tools, machines, structures, or equipment involved. Continue on second piece of paper if necessary):

____

____

____

Nature of Injury (fully describe nature and extent of injuries sustained including the body part(s) involved. Continue on second piece of paper if necessary):

____

____

____

Was medical treatment received? ☐Yes ☐No If "Yes" list medical provider/facility:_________________________________

Shift start time:____________ Hours scheduled to work:_________ Days scheduled per week:___________

Did the employee leave work or miss any time from work as a result of their injury? ☐Yes ☐No

If "Yes" provide the last date worked:__________________ Did employee return to work? ☐Yes ☐No

Date employee returned to work?___________________ Returned to: ☐ Regular Work ☐ Modified Work

Was employee paid in full for date of injury? ☐Yes ☐No

Supervisor evaluation- was this injury the result of (check all that apply):

☐Unsafe condition
☐Unsafe act or poor judgment
☐Failure to use protective devises
☐Defective tools or equipment
☐Lack of knowledge
☐Weather conditions
☐Unsafe speed
☐Poor ergonomics
☐Unsafe material handling
☐Lack of experience/training
☐Unsafe illumination or ventilation
☐Poor housekeeping /congestion
☐Horseplay
☐Other:_____________________

Was the accident witnessed? ☐Yes ☐No If "Yes", provide the following information:__________________________

Witnesses name:____ Telephone:_______________________

Witnesses name:____ Telephone:_______________________

Name of supervisor completing report:_______________________________ Date:_____________________________

Supervisor's Telephone:____ Best time to call:___________________

Division Director's Signature:______________________________________ Date:_____________________________

Submit completed report to Human Resources. Retain a copy for Division/Department record.