

Supervisor's Investigation Report

Name of Employee: _____ SSN: _____

Date of Accident: _____ Date of Hire: _____

Time of Accident: _____ Place of Accident: _____

When did employee report the incident? _____

Who was the incident reported to? _____

Department: _____

Were there witnesses? Yes ___ No ___ Names: _____

(If Witnesses, please fill out witness statements) _____

Body parts injured: _____

Describe accident: _____

Was employee using machinery, tools, or other materials? Explain: _____

What caused the accident? (Describe unsafe act, unsafe conditions, defective equipment or material)

What action will has been taken to prevent this from happening again?:

Has the employee been sent to a physician? Yes ___ No ___ First Aid? Yes ___ No ___

Physician/Clinic: _____

Did employee leave work? Yes ___ No ___ Date: _____ Time: _____

Has/will employee return to work? Yes ___ No ___ Date: _____

Will employee likely be off work more than 7 days? Yes ___ No ___ Unknown _____

Comments: _____

Signature of Supervisor

Date

**Claims Administrative Services
Old Glory Insurance Company
P.O. Box 7500
Tyler, TX 75711
Phone: (800) 765-2412
Fax: (903) 509-1888**

