All completed reports need to be sent to Risk Management. A Claim number will be assigned by Risk Management.

Claim#_____ **Date of Accident/Incident** _____ **Department** _____

SUPERVISOR'S ACCIDENT / INCIDENT INVESTIGATION REPORT

Employee Name	Number of Previous Work Injuries	How Long In Present Job?

Job Title	Date And Time Of Accident	Did The Employee Use Safety Devices As Provide By The Employer?

Injury Sustained	Type of Medical Treatment Required

Environmental Conditions (Weather, Visibility, ETC.)

Describe Clearly How The Accident Occurred, Including Equipment, Property or Material Involved…All Details

_____

_____

_____

_____

_____

_____ Estimated Damage _____

List All Eyewitness

_____

_____

Cause:

Was Accident caused by an unsafe act? Yes_____ No _____ If Yes, Please List Causes: _____

_____

Was Accident caused by unsafe Conditions? Yes_____ No _____ If Yes, Please List Causes: _____

_____

What Action Has or Will Be Taken To Prevent Recurrence?

_____

_____

_____

Investigated By (Immediate Supervisor)	Date	Reviewed By (Department Director)	Date

Okaloosa County RM-A01 (2/98)

Original Copy to Risk Management
Make a Copy for your Department

RM/2003/Workerscomp