



# Supervisor's Accident/Incident Investigation Report

1. Employee's Name	2. Job Title	3. How Long in Present Job?
4. Incident Location	5. Time AM <input type="checkbox"/> PM <input type="checkbox"/>	6. Date (Month, Day, Year)
7. Injury Sustained	8. Type of Medical Treatment Required	
9. Environmental Conditions (Weather, Visibility, Etc.)	10. Was Employee Using Required Safety Devices/PPE?	
11. Describe what happened. Identify all of the equipment, property, and/or other materials involved. How did this incident occur? Why?		
12. Identify All of the Eyewitnesses (if any).	13. Estimated Cost of Damage/Loss	
14. Did any Unsafe Acts, Unsafe Condition, and/or any Unsafe Equipment/Other Property contribute to this incident? If so, how?		
Were any County Employees drug tested following this incident?		
15. What steps have been taken (and by whom) to prevent similar incidents in the future?		
16. Investigating Supervisor Printed Name: _____ Signature: _____ Date: _____	17. Department Manager or Director Printed Name: _____ Signature: _____ Date: _____	

**NOTE:** For vehicle incidents, attach a copy of the Florida Traffic Accident Report.

**Send original form to Risk Management – Keep a copy.** (Form Revised – July 16, 2018)