

SAN JOAQUIN COUNTY

SUPERVISOR'S REPORT OF ACCIDENT

Injured Employee: \_\_\_\_\_

Department: \_\_\_\_\_ Phone: \_\_\_\_\_

Accident Date \_\_\_\_\_ Time \_\_\_\_\_

Was First Aid or Medical Attention Given?  YES  NO

If so, by Whom? \_\_\_\_\_

Physician's Name and Address: \_\_\_\_\_

\_\_\_\_\_

Describe Injury and Part of Body Injured: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Detailed Description of the Accident (Who-What-When-Where-Why) \_\_\_\_\_

\_\_\_\_\_

Names of Witnesses \_\_\_\_\_

\_\_\_\_\_

Cause of Accident (Describe Unsafe Acts & Unsafe Conditions) \_\_\_\_\_

\_\_\_\_\_

Did Employee Lose Time From Work?  Yes  No

What Steps Have Been Taken to Avoid Similar Accidents: \_\_\_\_\_

\_\_\_\_\_

SUPERVISOR'S SIGNATURE

ORIGINAL – COUNTY RISK MANAGER