



SUPERVISORS ACCIDENT / INCIDENT INVESTIGATION REPORT

PART I: BASIC INFORMATION

1. Name of Employee Involved:	2. Job Title:	3. Department:
4. Phone Number:	5. Email Address:	6. How Long Worked in Present Job:
7. Location of Incident:	8. Date of Incident:	9. Time of Incident:
10. Any Injuries Sustained: <input type="checkbox"/> Yes (list below) <input type="checkbox"/> No	11. Type of Medical Treatment Required: <input type="checkbox"/> First Aid <input type="checkbox"/> Emergency Services <input type="checkbox"/> N/A	
12. Employee Wearing PPE: <input type="checkbox"/> Yes (list below) <input type="checkbox"/> No	13. Environmental Conditions (weather, visibility, etc.):	

PART II: NAMES OF OTHER EMPLOYEES INVOLVED

PART III: WITNESSES

1. List (Print) Names of Any Witnesses & Phone Numbers:	2. Employee(S) Involved Drug Tested: <input type="checkbox"/> Yes <input type="checkbox"/> No
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PART IV: SUPERVISOR NOTIFICATION & COST

1. Name (Print) of Supervisor:	2. Date & Time Supervisor Was Notified:	3. Estimated Cost of Damage / Loss:
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PART V: INCIDENT DESCRIPTION & DETAILS

Note: For vehicle accidents/incidents, attach a copy of the Florida Traffic Accident Report.

1. Description of What Occurred:
2. What Unsafe Act, Equipment, or Property Contributed to This Incident:
3. What Steps or Changes Have Been Made to Prevent a Similar Incident from Occurring in the Future:

PART VI: MANAGEMENT REVIEW / APPROVAL

1. Site Supervisor: Name (Print): _____ Signature: _____ Date: _____	2. Department Director: Name (Print): _____ Signature: _____ Date: _____
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Please submit this completed form to riskinfo@mykaloosa.com or workcompclaims@mykaloosa.com
For questions call Risk at 850-689-5977