



Supervisor Report of Accident/Incident

Type of Incident: Injury/Illness Vehicle Accident Property Damage/Equipment Incident

EMPLOYEE INFORMATION (TO BE COMPLETED BY SUPERVISOR WITH EMPLOYEE)

1. Name (First & Last):		2. Department/Division:		3. Job Title:	
4. Date of Birth (mm/dd/yy):	5. Social Security Number: XXX-XX-	6. Sex: M F	7. Marital Status: Married Widowed Separated Single Divorced		
8. # of Dependent Children:	9. Spouse's Name:		10. Home Address:		
11. City:	12. State:	13. Zip Code:	14. County:	15. Home Phone:	16. Cell Phone:
17. Supervisor Name:			18. Supervisor Phone Number:		

ACCIDENT/INCIDENT INFORMATION (TO BE COMPLETED BY SUPERVISOR WITH EMPLOYEE)

19. Date of Accident/Incident: 20. Time of Accident/Incident: : am pm

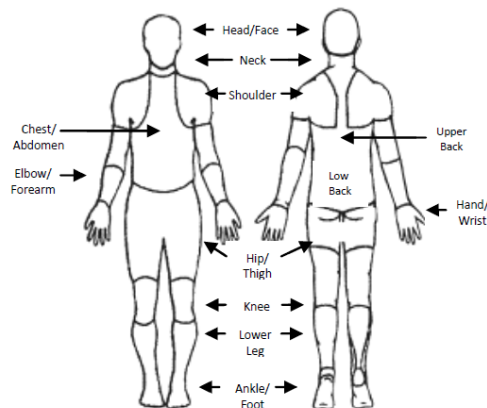
21. Incident Description (Describe, in detail the events before, during and after the incident):

COMPLETE THE FOLLOWING INFORMATION IF ACCIDENT/INCIDENT INVOLVED INJURIES

22. Was the employee treated at a medical facility? Yes No If yes, where?

23. Was first aid provided? Yes No If yes, who provided first aid?

24. Specify what body part was injured (Print and have employee shade in affected area):



25. Specific location of where the injury/illness occurred (stairs, conference room, parking, storage closet, etc.):

26. Address of Where Injury or Exposure Occurred, or Name of Business:
Street Address:

27. City: 28. State: 29. Zip: 30. County:

31. List Witnesses Name and Phone #:

COMPLETE THE FOLLOWING SECTION IF ACCIDENT/INCIDENT INVOLVED A CITY VEHICLE, EQUIPMENT, OR PROPERTY DAMAGE				
32. Year:	33. Make:	34. Model:	35. Vehicle License Number:	36. Vehicle/Equip. #
37. Reported to Police: Yes No N/A		38. Police Report #:		
39. Weather Conditions (select all that apply):		Clear	Cloudy	Raining Windy Foggy Snow/Sleet
40. Purpose of which vehicle/equipment was being used:				
41. Were photos taken of the vehicle/property damage: Yes No If yes, please email photos to HR Department.				
42. Was a post-accident drug screen given? Yes No If, no please state why?				
43. Describe the damages:				
SUPERVISOR'S INVESTIGATION & CORRECTIVE ACTIONS:				
44. What factors contributed to the accident/incident? (list any unsafe acts or conditions that may have caused the event i.e. lack of training, broken equipment, no written job procedures, employee not wearing correct PPE, etc.)				
45. What action will you take or recommend for preventing similar accidents/incidents?				
MEDICAL STATEMENT:				
I am declining medical attention at this time. I understand that if medical attention becomes necessary, I will immediately contact HR at 830-221-4390. Employee Initials: _____				
REQUIRED SIGNATURES:				
I hereby certify that the information above is true and correct to the best of my knowledge. I further understand that any falsification of information regarding an accident/incident may result in disciplinary action up to and including termination of employment.				
Employee's Signature:			Date:	
Supervisor's Signature:			Date:	

SUPERVISOR TO SEND COPIES TO:

SAFETY COORDINATOR

Kolby Burkhardt

Cell: 830-360-0799

KBurkhardt@nbtexas.org

HUMAN RESOURCE ASSOCIATE

Sonia Mendez

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HR FAX 830-608-2123