NCYF
NORTHEAST CENTER FOR YOUTH & FAMILIES

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Supervisors Accident Investigation Report

Today's Date: _____ Date Reported:_____

Date of Injury: _____Time of Injury:_____AM / PM (circle one)

Injured Employee: _____ Occupation: _____

(First Name) (Last Name)

Employee's regular work hours:

Monday: _____ , Tuesday: _____, Wednesday: _____, Thursday: _____,Friday:_____

Saturday:_____, Sunday:_____

Accident Information (describe fully how accident or injury occurred): _____

_____

_____

_____

Accident Location (room, building, etc): _____

Nature of Injury and Body Part: _____

_____

Major Cause of Accident: _____

Was Injury sustained in course of regular duties? ❑ Yes ❑ No

Treatment Received: First Aid: _____ by: _____

Doctor: _____

Hospital: _____

Taken by: _____

Professional Treatment Refused By Employee: *(Employee Signature)*_____

Did Employee continue to work if professional treatment was refused: ❑ Yes ❑ No

Has employee returned to work if professional treatment was sought?

❑ Yes Date returned: _____

(or will return next scheduled shift):_____

❑ No Last day worked: _____

Action taken to prevent similar accidents: _____

Safety Violations: _____

Witnesses (full names):_____

Remarks by Supervisor:_____

_____

_____ _____

Employee Signature Date signed

_____ _____

Supervisor Signature Date signed