

Supervisor's Report of Accident

WSU Environmental health & Safety

(Please complete & return to WSU Workers Comp, mc 3002.)

Phone (801) 626-7547 Fax (801) 626-8530

Injured Person's Information	
Name:	Soc. Sec. #:
Status (Check one) <input type="checkbox"/> * Employee <input type="checkbox"/> Student <input type="checkbox"/> Visitor	Supervisor (If employee):
	Job Position/Title:
Accident Information (To be completed by everyone)	
Accident Date:	Accident Location:
Accident Time:	
Task being performed when accident occurred:	
Date & time accident reported to supervisor:	
Accident results: <input type="checkbox"/> Injury <input type="checkbox"/> Fatality <input type="checkbox"/> Property damage	# Workdays lost:
Witness Name(s)	
Describe how the accident occurred:	
What actions, events, or conditions contributed most to this accident?	
What can be done to prevent future accidents of this type?	
Injury Information (To be completed by everyone)	
Medical Treatment: <input type="checkbox"/> First aid administered at workplace <input type="checkbox"/> Medical treatment required	
Signature Section	
Signature of supervisor:	Date: