Clear Form

HPS Mechanical, Inc.

Supervisor's Accident Investigation

(To be completed by the employee's supervisor or other responsible administrative official)

Location where accident occurred	Employer's Premises: Yes ☐ No ☐ Job site: Yes ☐ No ☐		Date of accident or illness
Who was injured?	☐ Employee ☐ Non-Employee		Time of accident a.m. ☐ p.m. ☐
Length of time with firm	Job title or occupation	Name of dept. normally assigned to	How long has employee worked at job where injury or illness occurred?
What property/equipment was damaged?			Property/equipment owned by:
What was employee doing when injury/illness occurred? What machine or tool was being used? What type of operation?			
How did injury/illness occur? List all objects and substances involved.			
Part of body affected/injured?	Any prior physical conditions? If so, what? Yes ☐ No ☐		
Nature and extent of injury/illness and property damaged (be specific)			

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

☐ Improper instruction	☐ Failure to lockout	☐ Unsafe arrangement or process
☐ Lack of training or skill	☐ Unsafe position	☐ Poor ventilation
☐ Operating without authority	☐ Improper dress	☐ Improper guarding
☐ Horseplay	☐ Improper protective equipment	☐ Improper maintenance
☐ Physical or mental impairment	☐ Unsafe equipment	☐ Inoperative safety device
☐ Failure to secure	☐ Poor housekeeping	☐ Other _____

Supervisor's corrective action to ensure this type of accident does not recur: _____

_____

_____

_____

Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures?... Yes ☐ No ☐

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? ..... Yes ☐ No ☐

Did employee promptly report the injury/illness? ..... Yes ☐ No ☐

Is there modified duty available? ..... Yes ☐ No ☐

Supervisor's name	Supervisor's signature	Phone#	Date

HPS Mechanical, Inc.

Employee's Report of Injury

(To be completed by the employee only.)

Employee's name: _____ Male☐ Female☐
Last First Middle

Date of birth: ____ ____ ____ Home telephone # (_____) _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Present classification: _____ How long employed here: _____

Social security No.: _____-_____-_____ Weekly salary: _____

Location of accident: _____
Address Area (loading dock, bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: (including events that occurred immediately before the accident):

_____

_____

_____

_____

Describe bodily injury sustained (be specific about body part(s) affected): _____

_____

_____

Recommendation on how to prevent this accident from recurring: _____

_____

Name of supervisor: _____ Phone# _____
Last First

Name(s) of witness(es): _____ Phone# _____
(Attach witness(es) report(s))

When did you report the accident to your supervisor? _____

Who did you report the injury to? _____

Do you require medical attention? Yes:☐ No:☐ Maybe:☐

Name of your treating physician: _____ Phone# _____

Signature of employee: _____ Date: _____

HPS Mechanical, Inc.

Accident Witness Statement

(To be completed by accident witness)

Injured employee's name: _____
Last First Middle

Name of witness: _____ Ph# _____
Last First Middle

Job title of witness: _____ How long employed here?_____

Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Location of accident: _____
Address/Name of building Area (bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: (including events that occurred immediately before the accident):

_____

_____

_____

_____

_____

Describe bodily injury sustained (be specific about body part(s) affected): _____

_____

_____

Recommendation on how to prevent this accident from recurring:_____

_____

Name of Witnesses Supervisor: _____ Ph#_____
Last First

Signature of Witness: _____ Date: _____