Print Form

SAN JOAQUIN COUNTY

SUPERVISOR'S REPORT OF ACCIDENT

Injured Employee:____

Department:_______________________________Phone:______________

Accident Date _____________________________ Time ___________

Was First Aid or Medical Attention Given? ☐ YES ☐ NO

If so, by Whom? ____

Physician's Name and Address: _______________________________

____

Describe Injury and Part of Body Injured:______________________

____

____

Detailed Description of the Accident (Who-What-When-Where-Why) ________________

Names of Witnesses____

____

Cause of Accident (Describe Unsafe Acts & Unsafe Conditions)________________

____

Did Employee Lose Time From Work? ☐ Yes ☐ No

What Steps Have Been Taken to Avoid Similar Accidents: ________________

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____
SUPERVISOR'S SIGNATURE

ORIGINAL – COUNTY RISK MANAGER

S&T – 20 Rev. 10/91 QPS

CANARY - DEPARTMENT