

DUPLIN COUNTY
Supervisor's Accident
Investigation Report for Employees

(To be completed by supervisor immediately after an accident.)

Employee Name _____ Dept: _____

Title: _____ Location: _____

Date accident occurred: _____ Time: _____ AM PM

Date reported to supervisor: _____

Apparent nature and extent of injury or illness:

Causative agent most directly related to accident (i.e. object, substance, material, machinery, conditions):

Unsafe act by injured employee and other personal factors (i.e. improper attitude, lack of knowledge or skill, slow reaction, fatigue): _____

Is personal protective equipment required (i.e. protective glasses, safety shoes, safety hat)? _____

Was employee injured while using PPE? _____

Detailed description (How did accident occur? Why? List any objects, equipment, tools used or any special circumstances that may have caused accident):

Corrective action taken and follow up:

Was medical or professional care needed? **YES** **NO**

If yes, list name of treating physician/hospital, address, and phone number:

Hospital: _____ Address: _____

Phone: _____

Physician: _____ Address: _____

Phone: _____

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What time did the employee's shift begin on date of accident? Time: _____ AM PM

Did employee work the remainder of shift following accident? YES NO

If no, list time employee' shift ended: Time: _____ AM PM

List any witnesses to the accident: _____



Date accident investigated: _____

Immediate Supervisor: _____
(Print)

Immediate Supervisor: _____
(Signature)

Date Signed: _____

Department Head: _____
(Signature)

Date Signed: _____

County Manager: _____
(Signature)

Date Signed: _____

**This form must be completed within 24 hours after the accident is reported.*