**LOCATION:** _____

**Tel. (  ) _____ - _____**

# *SUPERVISOR'S ACCIDENT REPORT*

**Date & Time Reported To You:**
**____ : ____ __ M ___/___/___**

## INJURY INFORMATION

| | | | | |
|---|---|---|---|---|
| Employee Name: | | Social Security No.: - - | Department Code | Job Title: |
| Date of Hire: | Date of Accident: | Time of Accident: AM☐ PM☐ | Body Part Injured: | Nature of Injury |
| Medical Attention Required?: Yes☐ No ☐<br>Yes, but Declined to seek treatment. ☐<br>Offer of Medical Treatment Declined Form Signed? Yes☐ No☐ | | Name of Physician:<br>Phone No.: (  )____/____/____ | | Approved Provider?<br>Yes ☐ No ☐ |
| Description of Accident and Any Injury: | | | | |
| Where specifically did accident Occur: | | Was First Aid Given?<br>Yes ☐ No ☐ | BBP Exposure?<br>Yes ☐No ☐ | Your Premises?<br>Yes ☐No ☐ |
| Was the employee utilizing any required safety equipment? ☐Yes ☐No | | Was this the employee's normal job duty?<br>☐Yes ☐No | | Recorded on OSHA Log? Yes ☐No ☐ |
| Work Status:<br>Full Duty ☐ Transitional Duty ☐ Off Work ☐ | | Actual Date Off Work? | Transitional Duty RTW Date: | Full Duty RTW Date: |
| Employee Wages:<br>Salary ☐ Hourly ☐ | Base Salary:<br>Weekly ☐ Monthly ☐ | If Hourly, Rate: | If Salary, Amount: | No. of Hrs Regularly Worked Per Week: |
| Any Witnesses?<br>Yes ☐ No ☐ | Witness Name: | | Witness Telephone Number: | |
| ***WITNESS SHOULD COMPLETE FORM*** | Witness Name: | | Witness Telephone Number: | |

**Did you remember to have any witnesses complete a Witness Statement Form?** Yes ☐ No ☐

***ALL EMPLOYEES RECEIVING MEDICAL TREATMENT MUST PROVIDE YOU WITH THE TREATING PHYSICIANS RELEASE TO WORK PRIOR TO BEING ALLOWED TO RETURN TO WORK.***

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and may subject such person to criminal and civil penalties.

| | |
|---|---|
| Supervisor's Signature: | Date: |

 - Fax this form to: (210) 494-7694 or mail to: P.O. Box 700370, San Antonio, TX 78270