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 ☐ Yes, but Declined to seek treatment. ☐ Offer of Medical Treatment Declined Form Signed? Yes☐ No☐		Name of Physician: Phone No.: ( )____/____/____		Approved Provider? Yes ☐ No ☐
Description of Accident and Any Injury:				
Where specifically did accident Occur:		Was First Aid Given? Yes ☐ No ☐	BBP Exposure? Yes ☐No ☐	Your Premises? Yes ☐No ☐
Was the employee utilizing any required safety equipment? ☐Yes ☐No		Was this the employee's normal job duty? ☐Yes ☐No		Recorded on OSHA Log? Yes ☐No ☐
Work Status: Full Duty ☐ Transitional Duty ☐ Off Work ☐		Actual Date Off Work?	Transitional Duty RTW Date:	Full Duty RTW Date:
Employee Wages: Salary ☐ Hourly ☐	Base Salary: Weekly ☐ Monthly ☐	If Hourly, Rate:	If Salary, Amount:	No. of Hrs Regularly Worked Per Week:
Any Witnesses? 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