Idaho State University

Supervisor's Accident Report

This form is for ISU employees or authorized volunteers who may become injured while performing their official duties.

Name of Injured Person: _____

Injured Person Contact Info: _____

Position & Department: _____

Supervisor Name & Title: _____

Supervisor Contact Info: _____

Location of Accident: _____

Date of Accident: _____ Time: _____ Date Supervisor Notified: _____

Was the injured prson on duty at the time of accident? ☐ YES ☐ NO

Did they leave work? ☐ YES ☐ NO Date: _____ Time Out: _____

Did they return to work? ☐ YES ☐ NO Date: _____ Time In: _____

Describe how the accident occurred. Include details such as the specific task being performed, any machinery, tools, or objects involved, and any factors that contributed to the accident.

Nature of Injury: _____

Part of Body Injured: _____

Name of Treating Physician or Hospital: _____

Was the accident caused by faulty equipment? ☐ YES ☐ NO

Was the accident caused by someone outside of ISU? ☐ YES ☐ NO

If yes, identify and explain: _____

Was protective gear or other safeguards provided and/or used? ☐ YES ☐ NO

Explain: _____

Did anyone witness the incident? ☐ YES ☐ NO If yes, identify: _____

What corrective action has or will be taken to prevent similar accidents? _____

_____

_____	_____	_____	_____
Injured Person Signature	Date	Supervisor Signature	Date

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