CITY OF SEWARD NEBRASKA
537 MAIN ST
PO BOX 38
SEWARD, NE 68434-0038

PH: 402-643-2928
FAX: 402-643-6491

# ACCIDENT INVESTIGATION REPORT TO BE COMPLETED BY SUPERVISOR WITH EMPLOYEE

## Employee Information

Name of Employee: _____ Date of Birth: _____

Home Address: _____ Social Security: _____

Home Phone: _____ Date Hired: _____

Cell Phone: _____ Rate of Pay: _____

Email Address: _____

Department: _____ Job Title: _____

## Accident Information

Date of Accident: _____

Date Accident report to Supervisor: _____

Number of hours worked per day: _____

Number of hours worked per week: _____

Time employee began work: _____

Time of Accident: _____

Location of Accident: _____

Type of Injury/Illness (e.g. lacerations to forearm): _____

Part of body affected (e.g. right forearm, lower back): _____

What are your injuries? (**IN DETAIL**): _____

Did you receive medical treatment: Yes ☐ No ☐ Not applicable ☐

Date you received medical treatment: _____

Did you miss any work: Yes ☐ No ☐

Wearing Personal Protective Equipment: Yes ☐ No ☐

Transported to Hospital: Yes ☐ No ☐

Name and Address of Doctor: _____

Describe IN DETAIL how the accident occurred and what you were doing: _____

ACCIDENT SEQUENCE: Describe in reverse order of occurrence events preceding the injury and accident. Starting with the injury and moving backward in time, reconstruct the sequence of events that led to the injury.

A. Injury Event: _____

B. Acccident Event: _____

C. Preceding Event #1: _____

D. Preceding Event #2, #3, etc: _____

WITNESSES (Names and Phone Numbers): _____

Employee Signature: _____ DATE: _____

(Note by your signature, permission is granted to release your name to the safety committee)

UPDATED 04/22/2019

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**Additional Information**

CASUAL FACTORS. Events and conditions that contributed to the accident.

CORRECTIVE ACTIONS. Those that have been, or will be, taken to prevent recurrence.

DATE COMPLETED BY SUPERVISOR WITH EMPLOYEE: _____

PREPARED BY: _____ _____
Supervisor Signature Employee Signature

APPROVED BY: _____
Department Head Signature

DATE COMPLETED/SIGNED DOCUMENT SUBMITTED TO SAFETY COMMITTEE: _____

REVIEWED BY CITY ADMINISTRATOR _____
City Administrator Signature