Complete and send with the Employer's First Report to:

ACCLAMATION INSURANCE
MANAGEMENT SERVICES

W/C 3005 (6-01)

SUPERVISOR'S INCIDENT REPORT
WORKERS' COMPENSATION CLAIMS

					DATE & TIME RPT'D.
EMPLOYER				LOCATION	LOCATION CODE NO.
A. EMPLOYEE	NAME			JOB TITLE	
	DEPARTMENT			❒ LOST TIME ❒ NO L.T.	❒ FIRST AID
B. TIME AND PLACE OF ACCIDENT	DATE	HOUR	DEPARTMENT	IMMEDIATE SUPERVISOR	
	IDENTIFY EXACT LOCATION WHERE ACCIDENT OCCURRED (**BE SPECIFIC**)				
	JOB OR ACTIVITY AT TIME OF ACCIDENT (**BE SPECIFIC**)				

C. WITNESS – LIST OF NAMES AND ADDRESSES	

D. DESCRIBE ACCIDENT

E. ACCIDENT CAUSES (EXPLANATION)
UNSAFE CONDITION:

F. UNSAFE ACT

G. CORRECTIVE ACTION TAKEN – INCLUDE BOTH EMPLOYEE AND SUPERVISOR ACTIONS TO PREVENT FUTURE OCCURRENCES:

SIGNATURE OF IMMEDIATE SUPERVISOR DATE	SIGNATURE OF DEPARTMENT DIRECTOR DATE