

**SUPERVISOR'S REPORT OF ACCIDENT
TO BE COMPLETED BY SUPERVISOR OR MANAGER**

NATIONAL STORE NUMBER: _____

Employee: _____ S.S. #: _____ - _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Home Phone: (____) _____ - _____

Department: _____ Job Title: _____ Hire Date: ____/____/____

Length of Time in Occupation: _____ Wage: \$ _____ /hour

ACCIDENT INFORMATION:

Department Where Injured: _____

Date of Injury: ____/____/____ Day of Injury: _____ Time of Injury: _____

What Caused Accident? _____

State how injury occurred, what employee was doing, and what part of the body was affected:

List special protective equipment provided or required (such as goggles, special shoes, helmets, etc.).

Was such equipment being used or worn at the time of accident? YES _____ NO _____

If not, why not? _____

Witness Name: _____

Address: _____ Telephone #: (____) _____ - _____

REPORT DUE WITHIN 24 HOURS OF ACCIDENT:

Supervisor or Manager Filling out Report (Print Name): _____

Supervisor's Signature: _____

Company Address: _____

Telephone Number: (____) _____ - _____

**Submit this report to your store owner operator promptly & fax to
Sedgwick, Attn: Chuck Eastwood. Fax # 210-332-1590**