

**Southern Connecticut  
State University**  
**Supervisor's  
Accident  
Investigation  
Report 207-1**

**The supervisor must complete this form with the employee and then forward it to HR within 24 hours after the incident.**

Employee Name	Date of Birth / /	Department	Work Unit	Job Title
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Location of Incident	Date of Incident	Time of Incident a.m. p.m.	Date Incident Reported
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Body Parts Injured:	Did the employee need medical treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes indicate where)
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Cause of Injury (slip/fall, motor vehicle accident, assault):	Type of Injury (bruise, burn, strain):
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Briefly Describe the Incident:

List other employees involved or witnesses:

Corrective Action/Recommendations:

Supervisor's Signature:	Print Name:	Date: / /
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**This section of form for HR Use Only:**

Human Resources Comments & Recommendations:	Date Report Received: / /
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Call to check on employee status: \_\_\_\_\_

Incident sent to debriefing (Health & Safety Team): \_\_\_\_\_

Referred to WC Loss Control Consultant: \_\_\_\_\_