

# THE TULALIP TRIBES

NO. \_\_\_\_\_ SUPERVISORS REPORT OF AN ACCIDENT

Employee's Name: \_\_\_\_\_ Dept. \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

Date of accident: \_\_\_\_\_ Time of accident: \_\_\_\_\_ Time reported to you: \_\_\_\_\_

Did you witness the accident? \_\_\_\_\_ Who reported it to you? \_\_\_\_\_

Was worker injured? \_\_\_\_\_ First aid required? \_\_\_\_\_

Describe Injuries \_\_\_\_\_  
\_\_\_\_\_

If transported to medical facility, by who? \_\_\_\_\_

How long has the employee done this job? \_\_\_\_\_ Been in your dept.? \_\_\_\_\_

Has worker had safety training? \_\_\_\_\_ When and what type? \_\_\_\_\_

Describe the accident (include weather conditions if applicable, how many workers involved, injured, how many on project, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What were the causes of this accident? \_\_\_\_\_  
\_\_\_\_\_

Recommendations to avoid this in the future: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Will this be a time loss case? \_\_\_\_\_

**\*REMEMBER\*** Employee must furnish doctors release before returning to work!

Supervisors Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Compliance Officer: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_