



"TOSHA"

Tulalip Occupational Safety and Health Administration

SUPERVISOR'S REPORT OF AN ACCIDENT

Employee's Name: _____ Department: _____

Supervisor's Name: _____ Phone #: _____

Job Title: _____ Department: _____

Date of Accident: _____ Time of Accident: _____ A.M. / P.M.

Location of Accident: _____

Name of person you first reported accident to: _____ Time: _____ A.M. / P.M.

Supervisor's Name: _____ Department: _____

Name of Witness (if any): _____

Describe how the accident occurred in detail: _____

Weather Conditions (if applicable): _____

Was anyone else involved in the accident: _____ If so, who: _____

If you were injured, please explain your injury in detail: _____

In this original injury or re-injury: _____ If re-injury, date of original injury: _____

Was first aid administered: _____ If so, what type: _____

Date you sought medical attention: _____ Doctor's Name: _____

Office/Hospital: _____ Type of treatment required: _____

Did you miss any time from work: _____ If so, Dates & Time: _____

Date you will be able to return to work: _____

What is your current hourly pay: _____

What do you think could be done to avoid this accident from occurring again: _____

RETURN THIS ACCIDENT REPORT TO TOSHA ASAP!! REMEMBER, IF THIS WAS AN INJURY ACCIDENT, YOU WILL BE REQUIRED TO HAVE A "RETURN TO WORK RELEASE" FROM THE PHYSICIAN.

Signature: _____ Date: _____

TOSHA: _____ Date: _____