Claims Management of Missouri, LLC

SUPERVISOR'S ACCIDENT REPORT

Name of Insured: _____

Name of Employee: _____

Department: _____
Date of Accident: _____
Location: _____
Time of Accident: _____

Witness: _____(Complete Witness Statement)

Occupation: _____
Body Part Affected: _____
Nature/Cause of Accident: _____
Item Inflicting Injury: _____

Direct Cause of Accident:

_____

_____

Actions Taken to Prevent Recurrence:

_____

_____

Description of Accident: _____

_____

_____

_____

Supervisor: _____ Date: _____