



SUPERVISOR'S REPORT OF ACCIDENT

Please Fax completed form to (904) 262-2760; Attention: Risk Management Dept.

EMPLOYEE NAME: _____ SS#: _____

CLIENT COMPANY: _____ JOB POSITION: _____

SUPERVISOR'S NAME: _____

DATE/TIME OF ACCIDENT: _____ LOCATION: _____

TASK BEING PERFORMED WHEN ACCIDENT OCCURRED: _____

DATE/TIME REPORTED TO MANAGEMENT: _____

NAME (S) OF WITNESS (ES): _____

DESCRIBE HOW ACCIDENT OCCURRED: _____

ACCIDENT RESULTED IN: INJURY FATALITY

WAS FIRST AID GIVEN? (Y) (N) IF YES, BY WHOM? _____

WHERE DID EMPLOYEE GO FOR MEDICAL TREATMENT? _____

WHO TOOK THE EMPLOYEE FOR MEDICAL TREATMENT? _____

DESCRIBE THE INJURIES IN DETAIL: _____

WHAT CONTRIBUTED DIRECTLY TO THIS ACCIDENT? _____

HOW COULD THIS ACCIDENT HAVE BEEN PREVENTED? _____

WHAT COULD BE DONE TO PREVENT THIS IN THE FUTURE? _____

(PRINT NAME OF SUPERVISOR)

(DATE)

(SIGNATURE OF SUPERVISOR)

TELEPHONE

MATRIX EMPLOYEE LEASING

9016 Philips Highway

Jacksonville, Florida 32256

Phone: (904) 739-2722 Fax: (904) 262-2760