101 Tamaras Way, Hendersonville, TN 37075
888-743-4336 | Fax: 615-953-6292
wcclaims@tnrmt.com

111 Hazel Path, Hendersonville, TN 37075
615-826-4274 | Fax 615-826-6378
wcclaims@sectn.com

SUPERVISOR ACCIDENT INVESTIGATION REPORT

Supervisor Name: ____

Work Number: _________________________ **Alternate Number:** ____________________

Job Title: _____________________________ **Department:** _________________________

Identify the Employee Involved in the Accident: ______________________________________

Date of Accident: ________________________ **Time of Accident:** _____________________

Location of Accident: ____

Did the employee report the accident to you? **Yes** ______ **No** ______

If no, who reported the accident to you? ____

When did the employee report the accident to you? ____________________________________

What was reported to you about the accident? ____

____

____

Did the injured employee receive first aid? **Yes** ______ **No** ______

Was injury report or first aid delayed? **Yes** ______ **No** ______

If yes, why? ____

Was the employee referred for outside medical treatment? **Yes** ______ **No** ______

If so, where? ____

Was the employee provided a workers' comp panel? **Yes** ______ **No** ______

List Any Witnesses: ____

____

Was corrective action required? **Yes** ______ **No** ______

If yes, what correction action was taken? ____

Supervisor Signature ________________________ **Date** _________________

Please submit all paperwork via fax or email after reporting claim online.