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**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.*