

Supervisor's Accident Report Form

- In order to comply with OSHA reporting regulations, supervisors must complete this Accident Report Form within 2 business days following all work related accidents, injuries or illnesses.
- Completed forms must be submitted to Human Resources, mail stop D-HR or e-mailed to HRBenefits@mapfreusa.com.
- Once received by Human Resources, a claim will be filed with our Workers' Compensation Carrier.
- Human Resources will provide instructions and claim information to the injured employee.

Employee Information

Injured Employee Name:

Job Title:

Supervisor:

Regular Work Schedule (e.g. M-F 8:00 am to 5:00 pm):

Accident Information

Date of Accident:

Time of Accident:

Date accident was reported to employer or supervisor:

Person accident was reported to:

Location where accident happened (e.g. lobby entrance of building D, etc.):

Please describe what happened:

Describe the nature of the injury (e.g. strain, cut, bruise, etc.):

Body part affected (e.g. left hand, lower back, etc.):

Did employee leave work due to injury? Yes No
If yes, what time?

Date employee returned to work:

Witness Information

Were there any witnesses to the accident?: Yes No
If yes, please provide the name of witness(es):

Initial Treatment Information

Did the injured employee receive medical treatment: Yes No

If yes, please provide name of hospital or treatment facility where medical treatment was provided:

Was injured employee taken by emergency transportation?: Yes No

Submitter's Information

Supervisor Name:

Date/Signature:

Human Resources Use Only

Received By:

Date: