Complete and send with the Employer's First Report to:

ACCLAMATION INSURANCE MANAGEMENT SERVICES
P.O. Box 28100
FRESNO, CA 93729
800-559-9891

W/C 3005 (6-01)

SUPERVISOR'S ACCIDENT REPORT WORKERS' COMPENSATION CLAIMS

				DATE & TIME RPT'D.
EMPLOYER			LOCATION	LOCATION CODE NO.
A. **EMPLOYEE**	NAME		JOB TITLE	
	DEPARTMENT		☐ LOST TIME ☐ NO L.T.	☐ FIRST AID
B. **TIME AND PLACE OF ACCIDENT**	DATE	HOUR	DEPARTMENT	IMMEDIATE SUPERVISOR
	IDENTIFY EXACT LOCATION WHERE ACCIDENT OCCURRED (**BE SPECIFIC**)			
	JOB OR ACTIVITY AT TIME OF ACCIDENT (**BE SPECIFIC**)			

C. **WITNESS** - LIST OF NAMES AND ADDRESSES

D. **DESCRIBE ACCIDENT**

E. **ACCIDENT CAUSES (EXPLANATION)**
UNSAFE CONDITION:

F. **UNSAFE ACT**

G. **CORRECTIVE ACTION TAKEN** - INCLUDE BOTH EMPLOYEE AND SUPERVISOR ACTIONS TO PREVENT FUTURE OCCURRENCES:

NAME TITLE ( ) PHONE

SIGNATURE DATE