Shasta Head Start Child Development, Inc.
Injury Illness Prevention Program

Supervisor's Report of Accident

Injured Employee:____

Date of Injury: ___________________________ Time of Injury: ______________________________

Describe the injury and place it occurred: ____

____

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____

The accident resulted in*:*

[ ] No Treatment ____

[ ] First Aide given: ____

[ ] Medical Treatment at ____

This injury resulted in:

[ ] _____hours _____days loss of work

[ ] No loss of work

The following steps have been taken to prevent this type of accident from happening again: ________

____

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____ ____________________________

Supervisor Date Reported

Complete this form, make a copy and bring original to the HR
Dept. or fax to (530) 241-2081