

TO BE COMPLETED BY SUPERVISOR

Employee's Work Activity Code Number	Description	
When was this accident reported to you and by whom?		
What were the results of your interview with the witness(es)?	Did you obtain statement(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the employee's description of the accident concur with the witness(es)? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, explain.		
What are the specific causative factors in this accident?		
What are the specific recommendations you would make in order to prevent this type of accident from recurring?		
Would the employee benefit from any type of training? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Scheduled Training: _____	
If so, what training?		
EQUIPMENT Is there a repair order for the equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	When was it prepared?	Who was it submitted to?
Date of follow-up with employee and/or equipment order		
Supervisor Signature	Date Signed	

RETURN COMPLETED FORM TO: **WMMIC**
4785 Hayes Road, Suite 200
Madison, WI 53704
(608) 245-6891 PH
(608) 852-8647 FAX

FAX ACCIDENT REPORTS TO WMMIC AND MAIL ORIGINALS TO WMMIC. THE CITY SAFETY COORDINATOR (Room 406, City-County Building, FAX 261-4590) SHOULD RECEIVE COPIES OF ALL ACCIDENT REPORTS.