FORM A2

SUPERVISOR'S ACCIDENT REPORT

This form is to be completed by the supervisor or employee responsible for supervising the CASP probationer at the time of the injury. **Fax to CASP 417-865-6755 ASAP**.

PLEASE PRINT

Accident Date:__________________________ Agency Name: ______________________________

Name of Injured Probationer:____

Time probationer began work on day of the injury: _______________ Time of injury:______________

What was probationer doing just before the incident occurred? __________________________________

____

What happened?____

____

What was the injury?____

Did probationer leave the worksite or continue to work? If the probationer left the worksite, how? (Him/herself, ambulance, or other): ____

____

Who witnessed the injury? Include name, address and contact information for all individuals: ________

____

____

List all statements made by probationer regarding accident or injury:_____________________________

____

____

____

____

____

Supervisor/employee's signature ____ Date __________

Date reported to CASP: ______________________________ Date Faxed: _________________________