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

ACCLAMATION INSURANCE
MANAGEMENT SERVICES
P.O. Box 28100
FRESNO, CA 92729

SUPERVISOR'S ACCIDENT REPORT
WORKERS' COMPENSATION CLAIMS

COMPANY		LOCATION		DATE & TIME RPT'D / 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. WITNESSES - 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: