CMG Accident Report

Employee Name: _________________________

Taken to Hospital or Clinic? Y______N_______

Date of Accident: _________________________

Time of Accident: _________________________

Supervisor on Duty:________________________

Date Reported: ___________________________

Department: ______________________________

Location of where accident occurred (*be specific*)

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Description of Accident / Injury

____
____
____

Witnesses / Names

____

Corrective Action

____

________________________________ ________________________

Employee Signature Date

________________________________ ________________________

Supervisor Signature Date

Supervisor: Perform Accident Investigation, Implement Corrective Action, and submit this form and all medical paperwork to a CMG representative before the end of your shift.