SUPERVISOR'S EVALUATION REPORT

The circumstances of a collision or incident need to be investigated or received by a supervisor or investigator for loss prevention. Use this report in making the evaluation.
THIS FORM SHOULD BE SUBMITTED WITHIN 7 WORKING DAYS AFTER THE COLLISION OR INCIDENT

NAME OF EMPLOYEE INVOLVED IN COLLISION OR INCIDENT		JOB TITLE
LOCATION OF COLLISION OR INCIDENT (ADDRESS OR INTERSECTION)	DATE OF LOSS MO / DAY / YEAR	TIME AM ☐ PM ☐
EMPLOYEE INJURED: YES NO PASSENGER INJURED: YES NO TOTAL NUMBER OF INJURED	LENGTH OF TIME IN CURRENT JOB	HOURS WORKED ON DATE OF LOSS

DESCRIBE THE OCCURRENCE (ATTACH ADDITIONAL SHEETS IF NECESSARY). PLEASE IDENTIFY SOURCE OF INFORMATION (EX. DRIVER, POLICE, PERSONAL OBSERVATION).

CONTRIBUTING FACTOR
(CHECK THE MOST SIGNIFICANT)

HUMAN ________________ VEHICULAR ________________ ENVIRONMENTAL ________________

CHARGEABLE ________________ (INITIALS) PREVENTABLE ________________ (INITIALS) NONPREVENTABLE ________________ (INITIALS)

BRIEF JUSTIFICATION FOR FINDINGS (PLEASE IDENTIFY THE SOURCE OF INFORMATION).

REPORT PREPARED BY:

NAME ________________________________ TITLE ________________________________

BUREAU / DIVISION ____

SIGNATURE ________________________ PHONE NUMBER ________________ DATE ____________

Revised 9/2016