ALO-CINEMA INSTALLERS

INSTALLERS AND DISMANTLERS
OF MATERIAL HANDLING SYSTEMS

Supervisors First Report of Injury/Occupational Illness

Injured Employee Name: _____ SS#____/____/____
Date of Accident/Illness: _____ Time of Accident ____:_____
Foreman Name:_____

Job Site: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Injured Body Part(s): _____
How to Injury Occurred: _____
_____
Where Injury Occurred: _____
(Racks, Scissor Lift, Etc…)
What Medial Facility Was Employee Taken To: _____
(Please attach facility report)
Was Accident Preventable? Y ☐ N ☐
Explain How/Why: _____
Was Employee Following Proper Safety Procedures? _____
If Employee Fell, Was He/She Wearing A Safety Harness? _____
If Not, Please Explain Why: _____

Witness to Injury: Name: Job Title:
_____

Do You Dispute The Validity of This Injury/Illness? Y ☐ N ☐
(If yes please explain)_____
_____

Supervisor Signature: _____ Date: _____
THIS MUST BE DONE WITHIN 24 HOURS OF INJURY!

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