

SUPERVISOR'S REPORT OF INJURY

All injuries are to be taken seriously. The information you provide is required to complete a fair and thorough investigation of the injury, also may prevent another person from being injured. Follow instructions on back to help answer the following questions.

NAME: _____ TITLE/DEPT: _____

MAILING ADDRESS: _____ PHONE: _____

MALE FEMALE DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

DATE OF INJURY: _____ TIME OF INJURY: _____ (am/pm) INJURY LOCATION: _____

DID EMPLOYEE LOSE TIME FROM WORK? Y N IF YES, HOW MUCH (HOURS/DAYS): _____

DID THE EMPLOYEE RETURN TO WORK? Y N IF NO, GIVE EXPECTED RETURN DATE: _____

Please check "Y" for yes, and "N" for no: (if applicable)

- | | |
|--|---|
| 1. Was the injured person properly instructed in a safe and efficient method? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 2. Did the injured person violate any instructions? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 3. Was necessary protective equipment worn? (if applicable) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 4. Did poor housekeeping contribute to injury? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 5. Did horseplay cause the injury? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 6. Was the injury caused by something, which needed repairs? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 7. Should a guard be provided? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 8. Did any bodily defect contribute to injury? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 9. Was the injury caused by an unsafe act? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 10. <i>Did the injured report the injury to, the supervisor, within 24 hours?</i> | <input type="checkbox"/> Y <input type="checkbox"/> N |

Specify injury, what part of the body was injured: _____

Describe how the injury happened: _____

List Witness: (If any) _____

Unsafe Acts/Unsafe Conditions: (Describe any unsafe acts of people and unsafe conditions of equipment involved)

Actions Taken/Remedies: (What have you done to correct the conditions or to prevent any future injuries?) _____

DID THE EMPLOYEE GO TO THE DOCTOR OR HOSPITAL? Y N **IF YES, COMPLETE THE FOLLOWING:**

Name of Clinic or Hospital: _____ Date of visit: _____

DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKER'S COMPENSATION? Y N **Explain:**

SUPERVISOR SIGNATURE: _____ **DATE:** _____

PLEASE SUBMIT ALL ORIGINAL DOCTOR SLIPS TO THE INSURANCE DEPARTMENT