

SUPERVISOR'S REPORT OF INJURY FORM

This report must be received within two (2) days of the date you report the injury:

Employee Name: _____

Social Security Number: _____ - _____ - _____

Accident Information: a.m. Date Last Date
Date: _____ Time: _____ p.m. Notified: _____ Worked: _____

Did Employee Return to Work? NO YES Date Returned to Work: _____

Where did the Accident Occur? _____

Description of Work Being Done at Time of Injury. _____

Type Injury and Extent: _____

Name, Address, and Phone Number of Hospital: _____

Name, Address, and Phone Number of Doctor: _____

Description of Accident: _____

Witnesses: _____

Was there any equipment malfunction: NO YES Equip. Type: _____

Describe damage to equipment or property: _____

SUPERVISOR MUST COMPLETE THE FOLLOWING

Unsafe Act or Condition that Caused Injury: _____

What Action Has Been Taken to Prevent Similar Injury? _____

Department: _____

Supervisor's Signature: _____ **Date:** _____