

# SUPERVISOR'S REPORT OF INJURY OR ILLNESS

ALL ITEMS MUST BE ANSWERED FULLY.

**WARNING: "WORKER'S COMPENSATION INSURANCE FRAUD IS A CRIME PUNISHABLE BY LAW."**

**EMPLOYEE**

Location (print) \_\_\_\_\_ State \_\_\_\_\_ Department \_\_\_\_\_ Phone Number \_\_\_\_\_

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employee # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Job Title \_\_\_\_\_ Length of Service with Company \_\_\_\_\_ Yrs.

Hourly Wage Rate \_\_\_\_\_ Job Being Performed at Time of Injury \_\_\_\_\_

Description of Incident:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**SUPERVISOR**

### INCIDENT DETAILS

Date of Incident \_\_\_\_\_ Time of Incident \_\_\_\_\_  AM  PM Date Reported \_\_\_\_\_

Shift:  AM  PM  Nights  Other Was Employee on Overtime?  Yes  No Time Shift Commenced \_\_\_\_\_

Incident: Location (specific area) \_\_\_\_\_ on employer premises?  Yes  No

Witness(es) to incident \_\_\_\_\_

Did Employee lose time due to the injury?  Yes  No First Aid Given?  Yes  No

Date worker left work \_\_\_\_\_ Time worker left work \_\_\_\_\_ Date worker returned to work \_\_\_\_\_

Complete if Applicable: **Medical Facility** \_\_\_\_\_ Doctor \_\_\_\_\_

(if Medical Attention is Sought, Complete State Form)

Follow up appointment scheduled?  Yes  No

Was time off authorized by the physician?  Yes  No If yes, how many days? \_\_\_\_\_

Treatment given  Prescription  Irrigation  Sutures  Tetanus Shot

Brace  Cast  Removal of Foreign Object  None

Ace Bandage  Other \_\_\_\_\_

#### PART OF BODY INJURED – MARK ALL THAT APPLY

- |                                  |                                                  |                                            |                                    |                                           |
|----------------------------------|--------------------------------------------------|--------------------------------------------|------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Head    | <input type="checkbox"/> Arm R-L                 | <input type="checkbox"/> Trunk             | <input type="checkbox"/> Hip R-L   | <input type="checkbox"/> Foot R-L         |
| <input type="checkbox"/> Face    | <input type="checkbox"/> Elbow R-L               | <input type="checkbox"/> Shoulder R-L      | <input type="checkbox"/> Thigh R-L | <input type="checkbox"/> Toe Identify     |
| <input type="checkbox"/> Eye R-L | <input type="checkbox"/> Forearm R-L             | <input type="checkbox"/> Chest             | <input type="checkbox"/> Knee R-L  | <input type="checkbox"/> Ribs R-L         |
| <input type="checkbox"/> Nose    | <input type="checkbox"/> Hand R-L                | <input type="checkbox"/> Back: Lower-Upper | <input type="checkbox"/> Leg R-L   | <input type="checkbox"/> Skin             |
| <input type="checkbox"/> Neck    | <input type="checkbox"/> Finger – Identify _____ | <input type="checkbox"/> Abdomen           | <input type="checkbox"/> Ankle R-L | <input type="checkbox"/> Other (describe) |

\_\_\_\_\_  
 \_\_\_\_\_

SUPERVISOR

**NATURE OF INJURY – MARK ALL THAT APPLY**

- |                                           |                                                 |                                              |                                               |                                                    |
|-------------------------------------------|-------------------------------------------------|----------------------------------------------|-----------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Abrasion         | <input type="checkbox"/> Puncture               | <input type="checkbox"/> Exposure – Chemical | <input type="checkbox"/> Inhalation           | <input type="checkbox"/> Burn: Heat – Chemical     |
| <input type="checkbox"/> Bruise – Crushed | <input type="checkbox"/> Fracture – Dislocation | <input type="checkbox"/> Hearing Loss        | <input type="checkbox"/> Fatality             | <input type="checkbox"/> Other ( <i>describe</i> ) |
| <input type="checkbox"/> Laceration – Cut | <input type="checkbox"/> Poisoning – Systemic   | <input type="checkbox"/> Sprain              | <input type="checkbox"/> Exposure – Heat/Cold | <input type="checkbox"/> Human Bite                |
| <input type="checkbox"/> Amputation       | <input type="checkbox"/> Dermatitis             | <input type="checkbox"/> Strain              | <input type="checkbox"/> Foreign Object       |                                                    |

**INVESTIGATION**

Date of Investigation \_\_\_\_\_ Person(s) Making Investigation \_\_\_\_\_  
Employee's Supervisor (*print name*) \_\_\_\_\_ Supervisor's Phone # \_\_\_\_\_  
Who was immediately in charge at the time of injury \_\_\_\_\_  
Was Employee Task Trained?  Yes  No If Yes, explain \_\_\_\_\_  
Were Safety Codes/Rules Violated?  Yes  No If Yes, explain \_\_\_\_\_  
Equipment Involved: Type \_\_\_\_\_ Model No. \_\_\_\_\_ Manufacturer \_\_\_\_\_

**CAUSE OF INJURY – MARK ALL THAT APPLY**

- |                                            |                                               |                                                 |                                         |                                         |
|--------------------------------------------|-----------------------------------------------|-------------------------------------------------|-----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Body Motions      | <input type="checkbox"/> Hot/Cold Temperature | <input type="checkbox"/> Flame/Fire/Smoke       | <input type="checkbox"/> Ladders        | <input type="checkbox"/> Slip/trip/fall |
| <input type="checkbox"/> Bldg/Structures   | <input type="checkbox"/> Conveyers            | <input type="checkbox"/> Furnitures/Fixtures    | <input type="checkbox"/> Machine – Misc | <input type="checkbox"/> Flying Objects |
| <input type="checkbox"/> Chemicals         | <input type="checkbox"/> Electrical – HV      | <input type="checkbox"/> Hand Tools – Non-Power | <input type="checkbox"/> Noise          | <input type="checkbox"/> Flash          |
| <input type="checkbox"/> Infectious Agents | <input type="checkbox"/> Electrical – LV      | <input type="checkbox"/> Hand Tools – Power     | <input type="checkbox"/> Particles      | <input type="checkbox"/> Other          |
| <input type="checkbox"/> Vehicles          | <input type="checkbox"/> Falling Objects      | <input type="checkbox"/> Hoisting Apparatus     | <input type="checkbox"/> Sharp Objects  |                                         |

**CAUSE OF INCIDENT – MARK AND EXPLAIN ALL THAT APPLY**

- |                                            |                                                      |                                            |                                            |                                          |
|--------------------------------------------|------------------------------------------------------|--------------------------------------------|--------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Equipment Failure | <input type="checkbox"/> Improper Material Handling  | <input type="checkbox"/> Excessive Speed   | <input type="checkbox"/> Poor Housekeeping | <input type="checkbox"/> Horseplay       |
| <input type="checkbox"/> Lack of Attention | <input type="checkbox"/> Wet Slippery Uneven Surface | <input type="checkbox"/> Procedure Failure | <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Other (explain) |

**ANALYSIS**

**Description of Incident**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**STEPS TAKEN TO PREVENT SIMILAR OCCURRENCE – MARK AND EXPLAIN ALL THAT APPLY**

- |                                                                 |                                                       |
|-----------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Reinstruction of Employee Involved     | <input type="checkbox"/> Formal Disciplinary Action   |
| <input type="checkbox"/> Reminder Instruction of all Employees  | <input type="checkbox"/> Installation of Guard Device |
| <input type="checkbox"/> Personal Protective Equipment Required | <input type="checkbox"/> Counseling of Employee       |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_