



Supervisor's Report of Employee Illness/Injury

TO BE COMPLETED BY SUPERVISOR OR DESIGNEE ONLY

Date of Report: _____

Name of Injured Employee: _____ Site: _____

Job Title: _____ Hrs/day: _____ Days/wk: _____

Where Did Accident or Exposure Occur?: _____

On Employer's Premises?

☐ Yes ☐ No

Specific Injury/Illness and Part of Body Affected (i.e. twisted ankle on right foot, second degree burns on left arm, etc.): _____

Equipment, Materials or Chemicals Employee Was Using When Event or Exposure Occurred:

(i.e. projector, mop, vacuum, Round-Up, paper cutter)

Specific Activity Employee Was Performing When Event or Exposure Occurred (i.e. moving boxes, mopping floor): _____

Completely Describe Location of Incident (including lighting, walking surface, weather, measurements and any other condition that could have contributed to or prevented the incident): _____

Describe Shoes, Physical Appearance or Any Other Characteristic that Would Contribute to Understanding How the Accident/Injury Occurred: _____

Describe Demeanor of Person Involved and Include Statements Made as "Excited Utterances": _____

How Injury/Illness Occurred: **Describe sequence of events and specific object or exposure that caused injury/illness.** (i.e. Stepped back and slipped. As he fell, he twisted back). If applicable, include details of location (weather, lighting, walking surface), physical appearance (type of shoes or clothing) and/or demeanor of injured employee (upset, clowning around). Use separate sheet if necessary. State facts, contributing factors, cite witnesses and support evidence.



Was Doctor Seen? ☐ Yes
(If yes, name and address of Doctor)

☐ No

If Hospitalized, Name and Address of Hospital

First Aid Applied? ☐ Yes ☐ No
(Please be specific)

Witnesses (use separate sheet if necessary):

Date of Injury/Illness: _____ Time: _____ ☐ a.m. ☐ p.m.

Time Employee Began Work on Day of Injury/Illness: _____ ☐ a.m. ☐ p.m.

Was Injury the Result of Anyone Other Than Employee? ☐ Yes ☐ No

If Yes, Explain: _____

Has Employee Returned to Work?

☐ No ☐ Yes, Date Returned: _____

Employee Status:

☐ Regular Full Time ☐ Part Time ☐ Sub

Have Any Steps Been Taken to Prevent Similar Accidents? ☐ Yes ☐ No

Please Describe: _____

If There Is a Safety Issue, Please Describe: _____

Supervisor Name

Supervisor's Signature

Date