SUPERVISOR'S REPORT

EMPLOYER:_____

NAME OF INJURED:_____

DATE OF INJURY:_____

Supervisor/Title (Completing this form):_____

Home Address:_____ Phone: ( )_____
(Street) (City, State, Zip code)

Your Current Job Title:_____ Length of time in position:_____

Length of time with current employer:_____

Positions held (if different than above)_____

INJURY INFORMATION:

Nature of Injury, Part of Body affected:_____

Describe the Accident and how it occurred:_____
_____

Cause of the Accident:_____

Witness(es):_____ Statement taken? (Y/N)_____
_____ _____
_____ _____

Any reason to question the accident, if so why?_____

Safety training provided to the injured? Yes_____ No_____

Corrective actions taken to prevent recurrence:_____

What Physician did the Injured choose from the Panel_____

Did the physician excuse the injured from work if so how long? _____
Did the Physician give work restrictions? If so, what are they_____
Was Modified work recommended? If so was work provided?_____

Please check the list below if completed:
_____ First Report _____Statement of the Injured
_____ Witness Statement _____ Designated Physician Form
_____ Physician Appt for Injured _____ Job Analysis(if restrictions are given)

_____ _____
Supervisor Signature Date