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
_____ Witness Statement
_____ Physician Appt for Injured
_____ Statement of the Injured
_____ Designated Physician Form
_____ Job Analysis(if restrictions are given)

_____ _____
Supervisor Signature Date