

Supervisor's Report of Injury

Department Name

Supervisor's Name

Date & Time of Incident

Injured Employee Name

Yes No

Did you see Incident?

Yes No

Employee Drug Tested?

Yes

Did employee follow Worker's Comp Procedures?

No

Supervisors' Statement

Please describe everything you know about the incident.

What preventative action was taken to minimize similar incidents in the future?

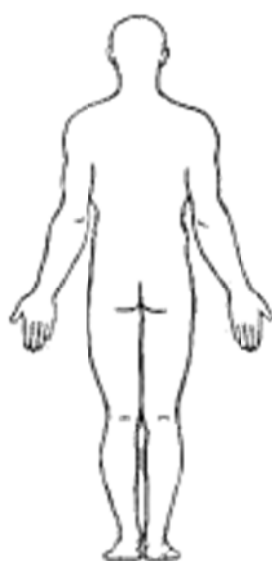
Employee Injured

Yes

No

Part of Body Injured

Please Circle Injured Body Part



Cause of Injury

Please Check Correct Box

- Bite/Sting
- Climb/Walk/Stand
- Cut/Scrape/Rub
- Exposure
- Fall/Slip
- Heat/Cold
- Occupational Hazard
- Stepped In/On
- Strike Against
- Assault
- Caught In/On
- Collapse
- Electric Shock
- Foreign Substance
- Motor Vehicle
- Strain/Overexert
- Struck
- Other
- NO INJURIES

Injury Type

Please Check Correct Box

- Abrasion/Scratch
- Bite/Sting
- Contusion/Bruise
- Strain
- Electric Shock
- Fracture/Break
- Exposure
- Burn
- Concussion
- Sprain
- Trauma
- Faint/Passed Out
- Laceration
- Puncture
- Dislocation
- Swelling
- Multiple Injuries
- Other
- NO INJURIES

Supervisor's Signature

Date