Ector County, Texas
Human Resources Department

Supervisor's Statement

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 descript everything you know about the incident.

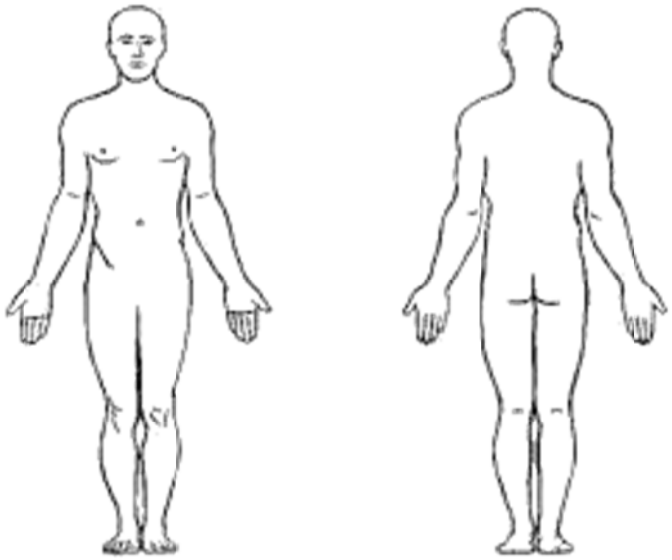
What preventative action was taken to minimize similar incidents in the future?

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