SUPERVISOR'S REPORT OF EMPLOYEE INJURY

NAME OF INJURED:		
DATE OF BIRTH:	SOCIAL SECURITY NO:	
EMPLOYEE'S ADDRESS:		
PHONE NUMBER:		
JOB TITLE:		
DATE OF ACCIDENT:	TIME OF ACCIDENT:	
DATE REPORTED:	TIME REPORTED:	
TIME EMPLOYEE BEGAN WORK:	A.M./P.M. (CIRCLE ONE)	
ACCIDENT LOCATION:		
SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, IF AVAILABLE:		
NAME OF MEDICAL FACILITY:		
DID INJURED LEAVE WORK?	DATE:	TIME:
DID INJURED RETURN TO WORK?	DATE:	TIME:
DESCRIBE HOW ACCIDENT OCCURRED:		
NAMES OF WITNESSES:		
WHAT STEPS HAVE BEEN TAKEN TO PREVENT SIMILAR ACCIDENT:		

DATE:	SUPERVISOR'S SIGNATURE: