Supervisor’s Report of Employee Injury

To Be Completed by Employer:

Employee Name:_____________________________________________________________
Occupation:____________________________________ Age:________________________
Date of Injury:_______________________________Time of Injury:_____________ am/pm
Date Reported:___________________________Time Reported:_____________ am/pm
Accident Location:___________________________________________________________
Type of Injury: ______________________________________________________________
Medical Facility:______________________________________________________________
Did Injured Leave Work?__________Date:__________Time Reported:_______am/pm
Did Injured Return to Work:________Date:__________Time Reported:_______am/pm

1. Describe how the accident occurred: __________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

2. Names of witnesses:_____________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

3. What steps have been taken to prevent similar accidents?: ______________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

Supervisor’s Signature:_______________________________ Date:___________________