



WORKERS' COMPENSATION SUPERVISOR'S REPORT

This form is to be completed by the **immediate supervisor** upon knowledge of an accident resulting in injury and should be sent to the Personnel Department within 24 hours from date of injury.

Injured Employee's Name:		Position/Department:	
Date of Injury:	Time of Injury:	Date Reported to You:	Time Reported:
Address where accident happened:			
Witnesses of the accident:			
Specific activity being performed when the accident occurred:			
Describe how the injury happened: (Be descriptive)			
Type of Injury:		Part of Body Affected: (Be descriptive.)	
Were safeguards or safety equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Were they used? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Possible preventative measures:			
Result of Accident: (Check all that apply.)			
<input type="checkbox"/> Death <input type="checkbox"/> Days away from work <input type="checkbox"/> Restricted work duty <input type="checkbox"/> Initial examination only			
<i>Provide all medical documentation of restricted work duty or return to regular duty without restrictions to the Personnel Department.</i>			
<i>If accident results in the employee missing more than 3 consecutive days, FMLA leave paperwork will need to be completed by the employee so that the leave can be designated as FMLA.</i>			
Immediate Supervisor's Signature:		Date:	
Print Immediate Supervisor's Name:		Supervisor's E-mail:	
Immediate Supervisor's Telephone Number:			