Supervisor's Report of Employee Injury

To Be Completed by Employer:

Employee Name:____

Occupation:__________________________________ Age:______________________

Date of Inury:_____________________________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:__________________