SUPERVISOR’S INCIDENT REPORT

This report should be completed within 24 hours of the incident while the facts are still fresh in the minds of witnesses and should be filed with the department responsible for the processing of Workers’ Compensation claims.

Name of injured employee _____________________________________________________________

Occupation when injured ___________________________ School _____________________________

Was employee performing regular occupation? __________ If not, what occupation? ______________

Was employee experienced/trained in this occupation? ______ Secondary Employment? ______________

Date of injury ___________________________ Hour of day ______ AM ____ PM ______

Describe the events which resulted in the injury or disease ________________________________

________________________________________________________

Primary Cause of Injury _______________________________________________________________

Action taken to prevent recurrence

Describe the injury/disease and indicate body parts affected (specify (L) or (R) side) ______________

Do you have any questions or concerns pertaining to this injury? Yes __________ No ___________

If “yes,” please explain _______________________________________________________________

Are you aware of any pre-existing or contributory injuries/conditions? _______________________

Name(s) of any witnesses _____________________________

Was medical treatment provided? _______ Doctor: ____________________________

Hospital: ____________________________

Were you notified by the injured employee of this injury? _______ If so, when? ______________

Did employee lose any time from work? __________ If so, when did disability start? ______________

Has employee returned to work? ______________ When? ____________________________

Light Duty _______ Regular Duty _______ Number of Hours _______ Rate of Pay $ ______________

Any Light Duty work available? ____________________________

_________________________  ____________________________
Date                                              Signature

_________________________  ____________________________
Phone number                                              (Position and Department)
Please copy this form onto GREEN paper if available.

Thank You