

SUPERVISOR'S REPORT OF WORK RELATED INJURY/ILLNESS

(TO BE COMPLETED WITH 24 HOURS OF FIRST REPORT OF INJURY)
PLEASE PRINT

EMPLOYEE: _____ DEPT: _____ POSITION: _____

DATE OF INJURY: ___/___/___ TIME: _____ AM PM DATE REPORTED: ___/___/___ TIME: _____ AM PM

DATE OF HIRE: ___/___/___ FULL TIME: ___ PART TIME: ___

LOCATION OF OCCURRENCE: _____

1. What was the employee doing at the time of the injury/onset of illness? _____

2. What was the cause or series of causes which led to the injury/illness? _____

3. Was the employee working with another party at the time of the injury: No ___ Yes ___ If "yes" Provide name(s) and telephone numbers of other persons directly involved in the activity:

_____ Also injured? Yes ___ No ___

_____ Also injured? Yes ___ No ___

4. Were there witnesses to the injury: Yes ___ No ___ Not aware of any at this time: ___

If "yes": Name: _____ Phone: _____

Name: _____ Phone: _____

5. Was this activity part of the employee's normal duties? Yes ___ No ___

IF "NO": 5a. Was employee instructed to perform this activity? Yes ___ No ___

5b. Explain the circumstances that led employee to be performing this activity: _____

6. Had the employee performed this activity prior to the injury? Yes ___ No ___ NA ___

7. Had the employee been trained on how to perform this job duty? Yes ___ No ___ NA ___

Are the training records available for review, if needed? Yes ___ No ___

8. Please describe the physical surroundings at the time of Injury. Include description of any conditions or circumstances that may have contributed to the injury and any corresponding warning signs that were in place. For example, if floor was wet, was there a "Wet Floor" sign?

(Questions continue on reverse)

9. Does this activity require the use of Personal Protective Equipment (PPE)? Yes ___ No ___

If "YES" 9a. Was employee correctly wearing the PPE? Yes ___ No ___

9b. Had the employee received training on the use of the PPE? Yes ___ No ___

10. Was any equipment, machinery or tool being used by the employee at the time of the injury? Yes ___ No ___

If "YES" 10a. List the equipment, machinery or tool(s). For equipment or machinery, list the manufacturer, make, model and serial number:

10b. Had employee received training on the use of the above? Yes ___ No ___ Unknown ___ NA ___
If yes, are training records available for review? Yes ___ No ___

10c. Was the equipment/machinery/tool in good working condition? Yes ___ No ___ Unknown ___

If "No", explain: _____

10d. Can the maintenance records be located? Yes ___ No ___ NA ___

10e. Was the employee correctly using the equipment/machinery/tool? Yes ___ No ___ Unknown ___

If "No", explain: _____

11. Describe any other circumstances that contributed to this injury/illness:

12. In your opinion, how could this injury/illness have been avoided?

COMPLETED BY:

MANAGER/SUPERVISOR: _____ TELEPHONE: _____

TITLE: _____ DEPARTMENT: _____

SIGNATURE: _____ DATE: ___/___/___

Please use addition pages as needed to provide all pertinent information regarding this employee injury/illness.

**If you have any questions regarding completion of this report, please call extension 7677.
Forward completed report to the Risk Management Program office (CM102).**