

SUPERVISOR'S REPORT OF EMPLOYEE INJURY

Name of Inured: _____

Date of Birth: _____ Job Title: _____

Date of Injury: _____ Time: _____ am ____ pm ____

Date Reported: _____ Time: _____ am ____ pm ____

Accident Location: _____

Nature of Injury: _____

Name of Medical Facility: _____

Did Injured Leave Work: _____ Date: _____ Time: _____ am ____ pm ____

Did Injured Return to Work: _____ Date: _____ Time: _____ am ____ pm ____

Describe How Accident Occurred: _____

Names of Witnesses: _____

What Steps Have Been Taken to Prevent Similar Accident: _____

Supervisor's Signature: _____ Date: _____

Employer: _____