

supervisor's report of employee injury

To Be Completed by Employer:

Employee Name _____

Occupation _____

Date of Injury _____ Time of Injury _____ *a.m.*
p.m.

Date Reported _____ Time Work Day Began _____ *a.m.*
p.m.

Accident Location _____

Type of Injury _____

Medical Facility _____

Did Injured Leave Work? _____ Date _____ Time Reported _____ *a.m.*
p.m.

Did Injured Return to Work? _____ Date _____ Time Reported _____ *a.m.*
p.m.

1. Describe how the accident occurred _____

2. Names of witnesses _____

3. What steps have been taken to prevent similar accidents? _____

Supervisor's Signature _____ Date _____

Contact Company at: (877)518-6702
Search Code: SIG01

