Supervisor's Report

OCCUPATIONAL INJURY/ILLNESS

TO BE SUBMITTED WITHIN **TWO DAYS** OF OCCURRENCE.

1. Employee's Name *(print)* 2. Job Title

3. Date *of injury/illness* 4. Date *reported* 5. Time *injury/illness reported* ☐ AM ☐ PM

6. Location *of injury/illness*

7. Is the employee to be paid full wages for the date of injury/illness? ☐ Yes ☐ No

8. Was the employee doing something other than his/her required duty at the time of injury? ☐ Yes ☐ No 9. If "Yes," please describe what, why, and directed by whom *(describe below)*:

10. Please describe in detail what the employee was doing, how it was being done and tools, people, or machines involved. If possible, give detail of weights, temperatures, chemicals, etc. *(describe below)*

11. Do you question the validity of this claim? ☐ Yes ☐ No 12. If "Yes," give reason *(witnesses, prior discussions, personal issues, or suspicion; describe below):*

13. What caused the injury/illness to occur? *(check all that apply)*

☐ Improper or defective equipment
☐ Location (poor layout or lighting)
☐ Lack of skill, training, or experience
☐ Lack of personal protective equipment
☐ Adequate skill but failure to execute and follow direction
☐ Inadequate safeguards, unsafe job design
☐ Housekeeping, clutter, spillage, breakage
☐ Material handling
☐ Poor ergonomics in workstation design
☐ Other *(describe below)*

14. What can be done to prevent such an accident from happening again? *(describe below)*

15. Who will assume responsibility to ensure the above is completed? *(describe below)* 16. When will this be completed

17. Supervisor completing this form 18. Telephone Extension

19. Department and Title 20. Today's Date

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