



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*)

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

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 _____