Supervisor's Report of Employee Injury

☐ **First Aid Claim**

☐ **Workers' Compensation Claim**

To Be Completed by Employer:

Employee Name _____

Occupation _____ Age _____

Date of Injury _____ Time of Injury _____

Date Reported _____ Time Reported _____

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 _____