SUPERVISOR STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS

Name of injured employee: _____

Department/School Site: _____

Position: _____ Employee Hours: _____

Date of injury or illness: _____Time: _____ AM _____PM_____

Time Employee reported injury: _____AM___PM____

Did the injured employee leave work due to this injury or illness? Yes _____ No _____ Time: _____

Name of person to whom the injury or illness was reported:_____

Timeliness of reporting: If the accident was not reported immediately, why not?

_____

_____

Location where accident or exposure occurred:

_____

Body part injured (check all that apply and indicate left and/or right):

_____ Head	_____ Upper back	_____ Finger (which?)	_____ Ankle
_____ Face	_____ Lower back	_____ Upper leg	_____ Foot
_____ Eye	_____ Arm	_____ Lower leg	_____ Toe (which?)
_____ Neck	_____ Wrist	_____ Knee	_____ Other_____

Nature of injury or illness:

_____ Scrape	_____ Burn	_____ Fracture	_____ Cold-related problem
_____ Cut	_____ Sprain/strain	_____ Skin problem	_____ Loss of consciousness
_____ Puncture	_____ Foreign body	_____ Chemical-related problem	_____ Respiratory
_____ Bruise	_____ Poisoning	_____ Heat-related problem	_____ Other _____

What was employee doing at the time of injury or exposure?

_____

_____

_____

Person, object or substance that directly injured employee:

_____

_____

_____

Check any of the following unsafe actions which you feel may apply:

_____ Haste/unsafe speed	_____ Improper procedure	____ Unsafe lifting
_____ Not authorized	_____ Unsafe equipment usage	_____ Unsafe position
_____ Disregard of instructions	_____ Defective equipment/tools	_____ Running/jumping
_____ Lack of knowledge/skill/training	_____ Inattention	_____ Poor Housekeeping
_____ Failure to use proper equipment	_____ Assault	_____ Act of other
_____ Inadequate protective gear	_____ Horseplay	_____ Physical handicap
_____ Carelessness	_____ Alcohol/drugs	_____ Other

_____I know the injury occurred on duty. _____ I have no specific knowledge that the injury occurred on duty

Was the injury or exposure witnessed? Yes _____ No ____

WITNESS INFORMATION

Name: _____ Name: _____

Address: _____ Address:_____

City/State/Zip: _____ City/State/Zip:_____

Telephone: _____ Telephone:_____

Do you have any reason to question the validity of the claim? YES ___ NO___
If yes, please provide an explanation_____

What steps have been taken or recommended to prevent a recurrence?

_____

_____

Comments:

_____

_____

Supervisor's signature: _____ Date:_____