SUPERVISOR INJURY REPORT FORM

Your Logo Here

Supervisor Investigation Form

Supervisor Name			
Title		Contact Information	
Employee Name			
Title		Employee ID or SSN	
Reported To		Reported Date	
Date of Injury		Time of Injury	
Time employee started work			
Type of Incident:	☐ Report Only (no medical treatment needed) ☐ Medical Treatment Required		

Post-Accident Drug Screen Ordered		Chain of Custody #	
Video of Incident:	☐ Yes ☐ No		
Location of Incident			
On Premises	☐ Office ☐ Shop ☐ Parking Lot		
Off Premises			
Name			
Address			
Description of events right before, during and after incident as described to you (supervisor)			

Witnesses	
Name	
Contact Information	

Nature of Injury	
☐ Assault/Robbery	☐ Inhalation, Ingest, or Absorb
☐ Amputation	☐ Motor Vehicle Accident
☐ Bite	☐ Multiple Injuries

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☐ Carpal Tunnel Syndrome	☐ Natural Disaster
☐ Caught in, under or between	☐ No Physical Cause
☐ Chemical Burn	☐ Other – Be Specific
☐ Chemical Exposure	☐ Puncture
☐ Cut, Laceration, or Scrape	☐ Repetitive Motion Injuries/Illness
☐ Foreign Body in Eye	☐ Soreness, Pain
☐ Fracture	☐ Slip, Trip, or Fall
☐ Heat (thermal) Burn	☐ Sprain, Strain, Tear, Pop
☐ Struck by/on	

Body Part Position

☐ Left ☐ Right ☐ Both

Body Part

☐ Abdomen	☐ Groin
☐ Ankle	☐ Head or Scalp
☐ Back/Lumbar	☐ Knee, Lower Leg
☐ Buttocks	☐ Mouth
☐ Chest	☐ Multiple (Check All that Apply)
☐ Ear(s)	☐ Neck
☐ Eye(s)	☐ Other – Be Specific
☐ Face	☐ Ribs
☐ Finger(s)	☐ Teeth
☐ Foot	☐ Thigh
☐ Toes	

Concerns regarding report or employee issues

_____ _____

Supervisor Signature Date

EMPLOYEE INJURY REPORT FORM

Employee Injury Report Form

Employee Full Name			
Employee address			
Phone number		Job Title	
Employee ID or SSN			
Date of Injury		Time of Injury	

Location of Incident

On Premises	☐ Office ☐ Shop ☐ Parking Lot
Off Premises	
Name	
Address	
Reported When and To Whom	

Describe the incident to include what you were doing right before the injury occurred, what happened to cause the injury

List All body parts injured and injuries incurred due to accident

Witnesses

Name		Contact Information	

Did you seek medical treatment for this injury outside of workers' compensation?

If so, name of Provider & Phone Number

Have you injured same body part(s) previously?

If so, provide details (when, nature of injury)

Have you received Workers' Compensation benefits before?

If so, provide details of Employer, Date of Workplace Injury, Nature of Injury sustained

_____ _____

Employee Signature Date