SUPERVISOR’S REPORT OF WORK RELATED INJURY/ILLNESS
(TO BE COMPLETED WITH 24 HOURS OF FIRST REPORT OF INJURY)
PLEASE PRINT

Employee: ___________________________ Dept: ___________ Position: ________________
Date of Injury: ____/____/____ Time: _______ AM PM Date Reported: ____/____/____ Time: _______ AM PM
Date of Hire: ____/____/____ Full Time: ____ Part Time: _____
Location of Occurrence: _______________________________________________________________________________

1. What was the employee doing at the time of the injury/onset of illness?
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

2. What was the cause or series of causes which led to the injury/illness?
____________________________________________________________________________________________
____________________________________________________________________________________________

3. Was the employee working with another party at the time of the injury: No___ Yes___ If “yes” Provide name(s) and
telephone numbers of other persons directly involved in the activity:
____________________________________________________________________________________________
Also injured? Yes ___ No____
____________________________________________________________________________________________
Also injured? Yes ___ No____

4. Were there witnesses to the injury: Yes ___ No ___ Not aware of any at this time: ____
If “yes”: Name: ___________________________ Phone: ___________________________
Name: ___________________________ Phone: ___________________________

5. Was this activity part of the employee’s normal duties? Yes____ No ____
IF “NO”:
5a. Was employee instructed to perform this activity? Yes____ No____
5b. Explain the circumstances that led employee to be performing this activity: ________________________
____________________________________________________________________________________________

6. Had the employee performed this activity prior to the injury? Yes ___ No ___ NA ___

7. Had the employee been trained on how to perform this job duty? Yes __ No __ NA ___
Are the training records available for review, if needed? Yes ___ No ___

8. Please describe the physical surroundings at the time of Injury. Include description of any conditions or circumstances that
may have contributed to the injury and any corresponding warning signs that were in place. For example, if floor was wet, was
there a “Wet Floor” sign?
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Office of Risk Management
9. Does this activity require the use of Personal Protective Equipment (PPE)? Yes ___ No ___

If “YES” 9a. Was employee correctly wearing the PPE? Yes ___ No ___

9b. Had the employee received training on the use of the PPE? Yes ___ No ___

10. Was any equipment, machinery or tool being used by the employee at the time of the injury? Yes ___ No ___

If “YES” 10a. List the equipment, machinery or tool(s). For equipment or machinery, list the manufacturer, make, model and serial number: ________________________________________________________________

10b. Had employee received training on the use of the above? Yes ___ No ___ Unknown ___ NA ___

If yes, are training records available for review? Yes ___ No ___

10c. Was the equipment/machinery/tool in good working condition? Yes ___ No ___ Unknown ___

If “No”, explain: ______________________________________________________________________

____________________________________________________________________________________

10d. Can the maintenance records be located? Yes ___ No ___ NA ___

10e. Was the employee correctly using the equipment/machinery/tool? Yes ___ No ___ Unknown ___

If “No”, explain: ______________________________________________________________________

____________________________________________________________________________________

11. Describe any other circumstances that contributed to this injury/illness:

____________________________________________________________________________________

____________________________________________________________________________________

12. In your opinion, how could this injury/illness have been avoided and what corrective action has been taken?

____________________________________________________________________________________

____________________________________________________________________________________

COMPLETED BY:

Manager/Supervisor: ___________________________________________ Telephone: ____________________

Title: ___________________________________________ Department: __________________________

Signature: ______________________________________________ Date: ___/___/___

Please use addition pages as needed to provide all pertinent information regarding this employee injury/illness.

If you have any questions regarding completion of this report, please call extension 4516. Forward completed report to the Risk Management office.