

## SUPERVISOR'S REPORT OF INJURY OR ILLNESS

Claim Number

This form must be completed thoroughly by employee's supervisor within 24 hours after an accident **PART I – GENERAL INFORMATION Employee Name** Title Social Security No. Address City/State Zip Home Phone Agency Location Work Phone Job Description and/or Assigned Duties of Employee (be specific): Number of Years in current job title: \_\_\_\_ Previous job title: Number of years previous title: Activity at time of accident/incident: Date of Accident/Incident Hour: ☐ AM **Exact Location** ☐ PM Did you witness? How was notice received? **Date Received** Time Received From Whom Notice Received Yes ☐ No ☐ Written ☐ Oral PART II - DETAILS OF ACCIDENT Description of Accident/Incident: ☐ No If yes, explain and provide name, address and phone number of negligent party (use reverse side if necessary): Description of Injury – Part(s) of Body Injured: Name(s) of Witness(es) (if none, so state): PART III - CAUSE OF ACCIDENT Describe any unsafe acts or conditions which contribute to the accident/incident: PART IV - CORRECTIVE ACTION TAKEN Was the condition above corrected (how)? Reported to higher authority (Name & Title)? Name and Title of Supervisor Did the incident result in any disciplinary action? Yes ☐ No