

StaffScapes, Inc.



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Phone: 303-466-7864; Fax: 303-466-7947

SUPERVISOR'S REPORT OF INJURY

*This report must be received by StaffScapes **immediately** after the injury has occurred so that necessary claim forms can be filed to insure payments.*

Employee's Name _____

Social Security Number _____

Accident Date _____

Time: _____ (AM/PM) Date Notified _____ Last Day Worked _____

Did employee return to work? YES _____ NO _____ Date returned _____

Where did accident occur? _____

Description of work being done at time of injury _____

Type of injury and extent _____

Name, Address & Phone # of Doctor _____

Description of Accident _____

Witnesses _____

Was there any equipment malfunction? YES _____ NO _____

If YES, describe malfunction _____

Describe damage to equipment or property _____

SUPERVISOR MUST COMPLETE THE FOLLOWING

Unsafe Act or condition that caused injury _____

What action has been taken to prevent similar injuries?

Company _____

Address _____

Supervisor _____ Date _____
