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 ____
Marital Status_______________ FT or PT________ Days Worked Per Week_________
Work Start Time__________ End Time_______________Accident Date ____________
Time:_________(AM/PM) Date Notified_____________ Last Day Worked _________
Did employee return to work? YES_____ NO_____ Date returned ________________________
Accident Occurred on Employers Premises? YES_____ NO_____
Where did accident occur? ____
Description of work being done at time of injury____
____
Type of injury and extent ____
____
Name, & Phone # of Treating Doctor or Clinic______________________________________
____
Description of Accident____
____
Witnesses ____
Was there any equipment malfunction? YES______ NO _____
If YES, describe malfunction ____
Describe damage to equipment or property____
____
Was there any safety equipment provided? YES______ NO_______
Was the safety equipment used? YES_____ NO_______
Describe safety equipment____
____

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 ____________________