SUPERVISOR'S FIRST REPORT OF INJURY

*This report is to be filled out by the **employee's supervisor** and must be received by StaffScapes **immediately** after the injury has occurred. Fines may be incurred if submitted after 24 hours.*

INJURED WORKER INFORMATION			
Employee Name:		☐ Full-time	☐ Part-time
Accident Date:		Date Notified:	
Time Work Began: ☐ AM ☐ PM		Time of Injury: ☐ AM ☐ PM	
Preferred Language:		Job Title:	

ACCIDENT/INJURY INFORMATION			
Did the accident/injury occur on company premises? ☐ Yes ☐ No			
If no, what is the address of the location of the accident/injury?			
Description of the accident and injury/illness *(please include information on any body parts that were injured if applicable)*:			
Injury Occurred Because Of: ☐ Intoxication	☐ Safety Violation	☐ Not Applicable	
Did the employee return to work? ☐ Yes ☐ No	Date Returned:		
Witness Name:	Was there an equipment malfunction? ☐ Yes ☐ No		
If yes, describe malfunction:			
Initial Treatment: ☐ None	☐ First Aid	☐ Clinic	☐ Emergency Room
Clinic or ER Location:			

SUPERVISOR'S ASSESSMENT	
Unsafe act or condition that caused injury:	
What action has been taken to prevent similar injuries:	
Company:	
Completed By:	Date: