



To be completed by Supervisor of Injured Worker and returned to Human Resources

Employee Name \_\_\_\_\_ Occupation \_\_\_\_\_  
Date of Injury \_\_\_\_\_ Time of Injury \_\_\_\_\_ a.m./p.m.  
Date Reported \_\_\_\_\_ Time Reported \_\_\_\_\_ a.m./p.m.  
Accident Location \_\_\_\_\_

1. Describe Injury (indicate body part, left, right, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Did Injured Leave Work? \_\_\_\_\_ Time Reported \_\_\_\_\_ a.m./p.m.  
Did Injured Return to Work? \_\_\_\_\_ Time Reported \_\_\_\_\_ a.m./p.m.

2. Describe how the accident occurred

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Names of Witnesses

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. What steps have been taken to prevent similar accidents?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Supervisor's Signature \_\_\_\_\_ Date \_\_\_\_\_