WORKER'S COMPENSATION CLAIM
SUPERVISOR'S INCIDENT REPORT

(TO BE COMPLETED BY EMPLOYEE & SUPERVISOR)
INJURY MUST BE REPORTED THE SAME DAY AS THE INCIDENT

Employee Name _____
Social Security # _____ Department _____
Address _____
Date of Birth _____ Telephone # _____

Date of Injury _____ Time of Injury _____
Location (**where**) injury occurred _____
Machine, tool or thing causing injury _____

Describe **fully how** injury occurred and state **what** employee was doing when injured and **describe the injury**_____
_____
_____
_____

Describe **why** injury occurred _____
_____
_____

What should be done to prevent this from occurring again _____
_____

Dr visit: Yes ____ No _____ Prescriptions: Yes ____ No _____

Employee's Signature _____ Date _____
Supervisor's Signature _____ Date _____
Department Head's Signature _____ Date _____

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What corrective action has been taken _____
_____

Safety Director's Signature _____ Date _____
Safety Rep's Signature _____ Date _____

Comments: _____
_____
_____