Supervisor's First Report of Employee Injury/Illness

To be completed by a supervisor following any employee injury, regardless of whether or not the employee leaves work or sees a doctor. Form must be submitted to the Facilities Services/Risk Management Office within 24 hours of injury.

Type of Incident (Please Check One):

INJURY ILLNESS INCIDENT ONLY (no medical care required)

Employee's Name: _____ Position: _____

Social Security #: _____ Employee ID: _____

Address: _____

E-mail: _____ Phone: _____

Date of Injury/Illness: _____ Time of Injury/Illness: _____ a.m./p.m.

On this date, what time did the employee begin work? _____ a.m./p.m.

Location Injury Occurred: _____

Nature of Injury and part of body involved (e.g. cut left hand, strained low back etc.): _____

Describe how injury/illness occurred (Who/What/When/Where/Why): _____

Names:

Yes _____ No

Did the employee see a doctor?* Yes No

Medical Provider: _____ Phone: _____

Did you provide a Claim Form (DWC Form 1)?* Yes No

Corrective Action Required? (If yes, explain) : _____

Your Name (Supervisor): _____ Department: _____

Date and time you found out about the injury/illness: _____ a.m./p.m.

How did you find out about the injury/illness? _____

_____

Comments: _____

_____ _____

Supervisor's Signature Date

**If