

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 _____
Where did accident occur? _____
Description of work being done at time of injury _____

Type of injury and extent _____

Name, & Phone # of Treating Doctor _____

Description of Accident _____

Witnesses _____
Was there any equipment malfunction? YES _____ NO _____
If YES, describe malfunction _____
Describe damage to equipment or property _____

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 _____
