ON-THE-JOB-INJURY REPORT

SUPERVISOR'S REPORT (To be completed by Supervisor or Designee. Original must be returned to Human Resources.)

Employee Injured _____ Work Location_____ Work Phone _____

Position _____Shift Hours_____ Time of Accident_____

Date of Accident_____ Place of Accident _____

Describe the Accident _____

_____

_____

Where was the employee taken after the Accident _____ By Whom _____

Description of Injury _____

_____

Projected length of Disability _____Anticipated Work Days Lost _____

Witness(es):

Name _____ Work Location_____ Work Phone _____

Name _____ Work Location_____ Work Phone _____

Did negligence cause this accident? _____Recommendations for improved safety

_____

_____

Supervisor's Comments _____

Supervisor's Signature _____ Date _____