SUPERVISOR'S INCIDENT REPORT FORM
****IMPORTANT PLEASE COMPLETE ALL SECTIONS****

To be completed by the injured employee's supervisor as soon as possible following the incident

Injured Employee's Name:		School/Dept.:	
Position:		Date of Accident:	
First Day of Lost Time:		Return to Work Date:	
When Did You First Learn of Any Claimed Injury or Accident:	Date:	Time:	AM ☐ PM ☐
Who Reported it to You?			
When Did You First Speak With the Employee About it?	Date:	Time:	AM ☐ PM ☐
Describe in detail what the employee reported to you (be as specific as possible about what was said):			
What areas of the body did the employee complain of (left hand, neck, back, etc.)? Be specific:			
Identify any potential Witnesses:			
Do you know of any pre-existing medical problems of the employee? Yes ☐ No ☐			
Do you question the occurrence of this accident/injury? Yes ☐ No ☐ If yes, please explain:			
Did the employee complete his or her shift? Yes ☐ No ☐			
Did the employee request/receive any medical treatment? Explain:			
Your Name (Print):			
Your Position:			
Your Contact Information:	Work Phone:	Email Address:	
Supervisor's Signature:		Date:	

Please submit this report with "Employee's Statement of Accident/Injury/Illness Report" to the Risk manager within 24 hours after notification of the accident