Supervisor Accident Investigation Report

NEW WORKERS COMPENSATION CLAIM

Incident Date: Incident Time: Injured Employee ID#:

REPORTING PARTY'S INFORMATION

Reporting Party is: Job Title: Name:

Campus/Facility Name:

Business Physical Address: City: State: Zip:

Cell Phone: Work Phone: Email Address:

EMPLOYEE SECTION (INJURED EMPLOYEE)

Employee Name: Job Title: Employee ID#: Location ID:

Home Mailing Address: City: State: Zip:

Cell Phone: Home Phone: Work Phone: Gender:

Work Email Address: Personal Email Address:

Martial Status: Spouse Name No of Dependents: Occupation:

Org 1 (Grade Level): Org 2 (Campus/Facility Name):

Supervisor's Name: Supervisor's Job Title:

Supervisor's Phone: Supervisor's Email:

INJURY SECTION (You will be able to attach documents to this section in the TriStar Portal. Look for "Attach Documents" button.)

How did the injury occur(describe the accident):

Supervisor Accident Investigation and Pre-Injury Report Submission Form

INJURY SECTION (CONTINUED)

Injury/Illness Description:

Cause of Injury

Nature of Injury

Body Part:

INCIDENT SECTION

Witness Name(s):

Descripiton of exactly where the incident occurred (incident location descriptions):

Incident Physical Address (incident address):

Report Date: Report Time:

Reported to (name of person):

Comments/Other Information:

PROVIDER SECTION (If medical treatment will be sought, name of treatment facility if known)

Did the Employee Seek Treatment: Provider Name:

Supervisor Accident Investigation and Pre-Injury Report Submission Form

SUPERVISOR'S SIGNATURE SECTION

Supervisor's Printed Name (First, Middle Initial & Last):

Supervisor's Signature:

Date Signed: