Supervisor's Report of Injury or Illness

1. Name of employer:	2. Name of supervisor:	3. Department:
4. Employee's name:	5. Job title or position:	
6. Date and time of event:	7. Location or address where event occurred:	7a. On employer property? □ Yes □ No
8. Date of knowledge of the event:	9. Name and title of person to whom the event was reported:	
10. If the event was not reported immediately, why not?		
11. Was employee given a claim form (DWC-1)? □ Yes (date: _____) □ No	12. Did employee sign and return the claim form (DWC-1)? □ Yes (date: _____) □ No	

13. Type of medical treatment required:
- □ No treatment needed
- □ Paramedics or EMT
- □ Emergency room
- □ Hospitalized overnight
- □ Medical treatment refused
- □ First aid
- □ Clinic

14. Medical treatment provider: (include name and address of facility)

□ Check if this is a pre-designated provider

15. What was the employee doing at the time of the event? (Attach separate sheet if necessary)

_____

_____

_____

16. Describe how the event occurred: (Attach separate sheets if necessary)

_____

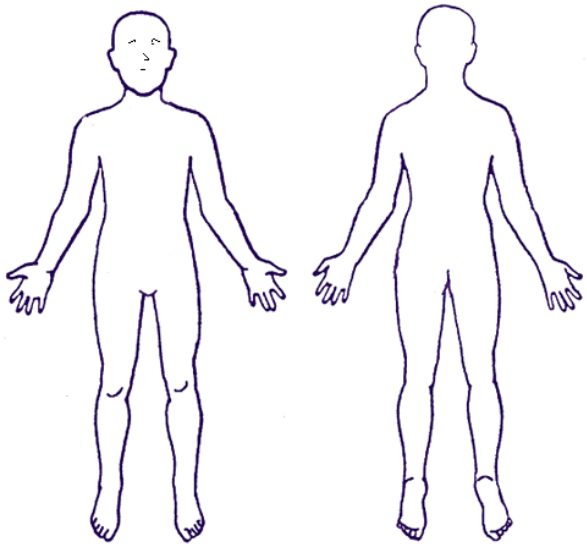
_____

_____

17. Type of Injury:
- □ Amputation/severance
- □ Bite/sting
- □ Burn
- □ Cancer
- □ Contusion, blunt trauma
- □ Crush
- □ Dermatitis
- □ Dislocation
- □ Fracture
- □ Inflammation
- □ Internal
- □ Puncture, penetrating trauma
- □ Repetitive motion injury
- □ Sprain/strain
- □ Tendonitis/synovitis
- □ Other: _____

18. Cause of Injury:
- □ Absorption, ingestion, inhalation
- □ Animal or insect
- □ Burn, scald, temperature extreme
- □ Caught in or between
- □ Cumulative Trauma
- □ Cut, puncture or scrape
- □ Electrical current
- □ Equipment, tools, machinery
- □ Explosion
- □ Foreign body
- □ Lifting
- □ Motor vehicle
- □ Pushing, pulling
- □ Repetitive motion
- □ Rubbed or abraded
- □ Slip, trip or fall
- □ Struck against, by
- □ Miscellaneous causes
- □ Other: _____

19. Mark affected area(s) on diagram:



20. Did employee lose time from work? □ No □ Yes – First day of lost time: _____

21. Has employee returned to work? □ No □ Yes – Date returned: _____
- □ Full duty
- □ Modified duty – Describe: _____

Supervisor's Report Employee's Name: _____

22. Was the event witnessed? □ No □ Yes – List witnesses (Attach separate sheet if necessary)

Name: _____ Name: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____
Telephone: _____ Telephone: _____

23. Check all conditions or actions that apply:

EQUIPMENT
- □ Defective machine
- □ Machine guards not in place
- □ Machine guards missing – need to be installed
- □ Improper tools
- □ Defective tools
- □ Improper protective equipment
- □ Defective protective equipment
- □ Inadequate protective equipment
- □ Other: _____

ENVIRONMENT
- □ Arrangement of equipment, work flow, tools
- □ Poor housekeeping – cleanliness and organization
- □ Inadequate lighting
- □ Inadequate ventilation
- □ Signs – inadequate signs or other forms of warning
- □ Walking surface
- □ Other: _____

PROCEDURE
- □ Unsafe procedures
- □ Procedures missing
- □ Procedures inadequate
- □ Other: _____

TRAINING
- □ Associate(s) lacks training
- □ Associate(s) needs retraining
- □ Other: _____

SUPERVISION
- □ Procedures not enforced
- □ Use of protective equipment not enforced
- □ Use of machine guards not enforced
- □ Other: _____

WORKER
- □ Horseplay, unsafe behavior
- □ Short cuts, carelessness
- □ Distracted, inattentive
- □ Other: _____

24. Describe the steps recommended or taken to prevent a recurrence:

_____
_____
_____

25. List any employer property that was damaged and describe the damage:

_____
_____
_____

26. Was the event caused by, or involve, a third party? □ No □ Yes – complete below.

□ Auto accident □ Rented or leased equipment □ Off-site activity □ Conference or seminar □ Construction area

Name and address of third party: _____
Description of involvement: _____

27. Other information:

Photographs taken? □ No □ Yes – by whom: _____
Police or fire called to event? □ No □ Yes – Agency: _____
Cal/OSHA contacted? □ No □ Yes – by whom: _____
Evidence preserved (contact Risk Management for guidance)? □ No □ Yes – by whom: _____

28. Comments: (Attach separate sheet if necessary)

_____

Completed by (print name): _____ Date: _____

Signature: _____ Phone no.: _____

□ Attachments