

SUPERVISOR'S REPORT OF INJURY, ILLNESS, OR ACCIDENT

Name of injured Employee		Job Title	
Department Name		Supervisor	
Date of Injury, Illness, or Exposure	Time of Injury, Illness, or Exposure	Date Reported	
Names of witnesses			

Type of injury, illness, or incident and all parts of body affected
(cut, strain, fracture, rash, etc. to right index finger, low back, left wrist, etc.)

Equipment, materials, and/or chemicals employee was using when the injury, illness, or incident occurred.

Specific activity employee was performing when the injury, illness, or incident occurred.

Was the employee(s) performing regular job duties at the time of the injury, illness, or incident occurred?
(If not, please explain)

How did the injury, illness, or incident occur?
(Please describe fully the events that resulted in the injury, illness, or incident. Use additional pages if necessary)

Had the employee been previously notified of the hazards associated with the incident? (Please explain)

Was a safety rule violated? yes no If yes, which one?

What corrective action will prevent recurrence?

Status of corrective action:

Do you question this claim? (If so, please explain)

How is the employee's performance		How is the employee's attendance	
Supervisor Signature	Manager Signature	Workers' Comp Officer Signature	
Date	Date	Date	

Due in Workers' Comp Officer within 48 hours of knowledge of injury, illness, or incident. Direct employee to call Company Nurse to report incident to a triage nurse .

REPORTE DEL SUPERVISOR DE LESIÓN, ENFERMEDAD, O ACCIDENTE

Nombre del empleado lesionado		Puesto de trabajo	
Nombre del departamento		Supervisor	
Fecha de la lesión, enfermedad, o exposición	Hora de la lesión, enfermedad, o exposición	Fecha en la que se reportó	
Nombre de los testigos			

Tipo de lesión, enfermedad o accidente y todas las partes del cuerpo afectadas (cortada, torcedura, fractura, irritación, etc. en el dedo índice derecho, espalda baja, muñeca izquierda, etc.)

Equipo, materiales y/o productos químicos que utilizaba el empleado cuando se produjo la lesión, enfermedad, o suceso.

Actividad específica que realizaba el empleado cuando se produjo la lesión, enfermedad, o incidente.

¿Realizaba el empleado o empleados sus tareas habituales en el momento en que se produjo la lesión, enfermedad, o incidente? (Si su respuesta fue “No”, explique)

¿Cómo se produjo la lesión, enfermedad o incidente?

(Describe detalladamente los hechos que provocaron la lesión, enfermedad, o incidente. Utilice páginas adicionales si es necesario)

¿Se había notificado previamente al empleado los peligros asociados al incidente? (Explique)

¿Se ha incumplido alguna norma de seguridad? sí no Si la respuesta fue “Sí”, ¿cuál?

¿Qué acción correctiva evitará que se repita?

Estado de la acción correctiva:

¿Cuestiona la validez de este reclamo? (Si su respuesta fue “Sí”, explique)

¿Cómo es el desempeño laboral del empleado?		¿Cómo es la asistencia del empleado?	
Firma del supervisor	Firma del gerente	Firma del oficial de compensación laboral	
Fecha	Fecha	Fecha	

Presentar ante el Oficial de Compensación para Trabajadores dentro de las 48 horas de tener conocimiento de la lesión, enfermedad o incidente.

EMPLOYEE STATEMENT

Name of injured Employee		Job Title	
Department Name		Supervisor	
Date of Injury, Illness, or Exposure	Time of Injury, Illness, or Exposure	Time work begins	
Names of witnesses			

Type of injury, illness, or incident and all parts of body affected
(cut, strain, fracture, rash, etc. to right index finger, low back, left wrist, etc.)

Equipment, materials, and/or chemicals you were using when the injury, illness, or event occurred.

Specific activity you were performing when the injury, illness, or event occurred.

Were you performing regular job duties at the time of the injury, illness, or event occurred?
(If not, please explain)

How did the injury, illness, or event occur?
(Please describe fully the events that resulted in the injury, illness, or event. Use additional pages if necessary)

Have you previously injured this part(s) of your body before this injury or illness occurred, or did anything else affect your performance? (Please be specific)

How do you feel now?

- I would like to be examined by a doctor at this time
 I would not like to be examined by a doctor at this time, because:

I certify that this is an accurate statement in my own words, which describes my injury, illness or incident and events leading to such result

Signature	Date
Home Address	Telephone Number

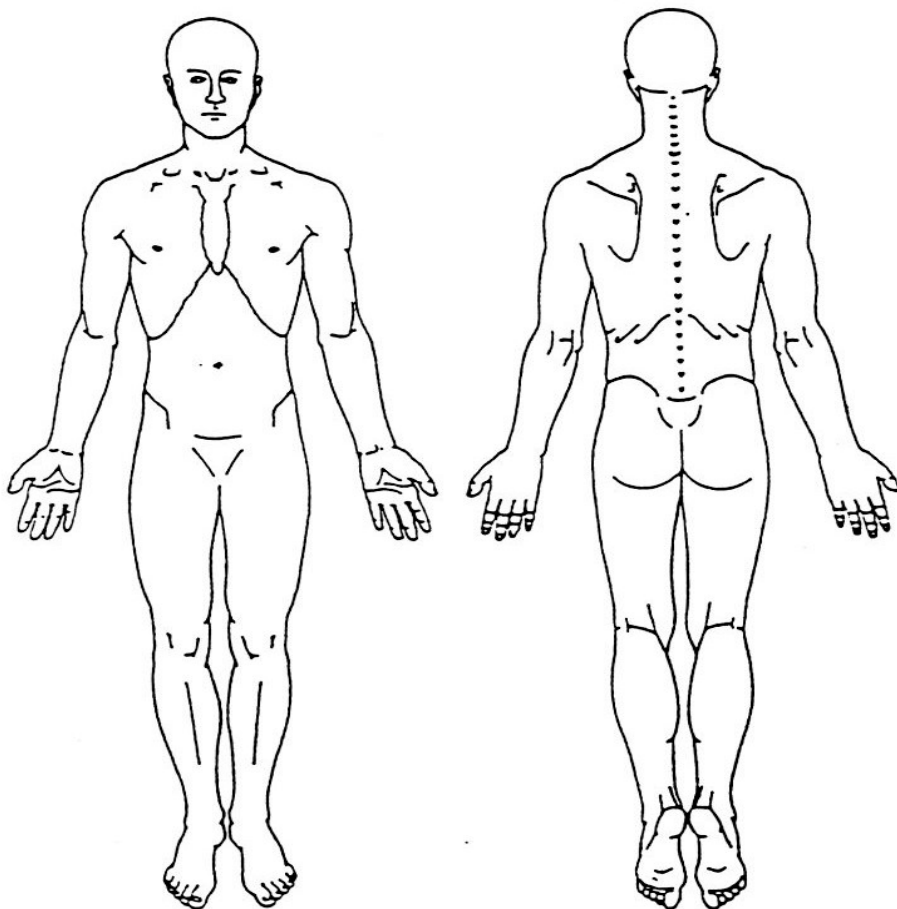
Please return this form to your supervisor when completed. Please call Company Nurse at 855-602-5267, code VCS11, whether you are examined or not.

Name: _____
Date of Injury: _____

BODY INJURY DIAGRAM

Instructions:

On the body diagram below, please indicate where your pain is located at the present time and draw the appropriate pain symbol using the **PAIN CODES**. Please do not indicate areas of pain that are not related to your present injury or condition.



PAIN CODES:

Burning: + + +
Stabbing: / / /
Cramping: XXX
Numbness: = = =
Pins & Needles: 0 0 0
Aching: > > >

Circle the number that best describes your current pain for your _____:
(body part)

0 1 2 3 4 5 6 7 8 9 10

If you are experiencing pain in other body parts, please state the body part and indicate your current pain by circling the number below:

Body part(s): _____

0 1 2 3 4 5 6 7 8 9 10

Employee Name (Print): _____

Date: _____

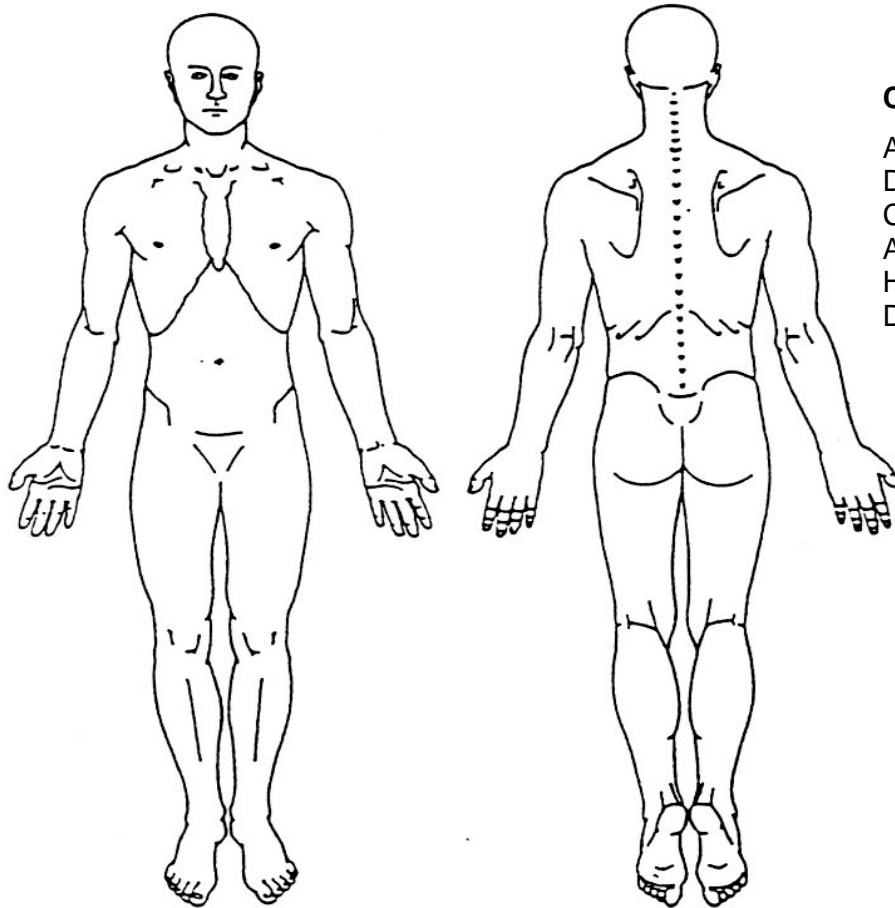
Employee Signature: _____

Nombre: _____
Fecha de la Lesión: _____
Partes del Cuerpo: _____

DIAGRAMA DE LESIONES EN EL CUERPO

Instrucciones:

En el diagrama de cuerpo a continuación, por favor indique donde tiene dolor por el momento y dibuje los símbolos de dolor apropiados utilizando los **CÓDIGOS DE DOLOR**. Por favor no indique áreas de dolor que no estén relacionadas a su condición o lesión actual.



CÓDIGOS DE DOLOR:

Ardor: + + +
Dolor Punzante: ///
Calambres: XXX
Adormecimiento: = = =
Hormigueo: 0 0 0
Dolor: > > >

Circule el número que mejor describe su dolor en su _____:
(parte del cuerpo)

0 1 2 3 4 5 6 7 8 9 10

Si está sintiendo dolor en otras partes del cuerpo, por favor indique la parte del cuerpo y el dolor actual circulando el número a continuación:

Parte(s) del cuerpo: _____

0 1 2 3 4 5 6 7 8 9 10

Nombre del Empleado (Letra de Molde): _____ Fecha: _____

Firma del Empleado: _____

WITNESS STATEMENT

Name of Witness		Job Title	
Department Name		Supervisor	
Name of Victim	Date of Injury, Illness, or Exposure	Time of Injury, Illness, or Exposure	
How do you know the victim?			

Type of injury, illness, or incident and all parts of body affected
(cut, strain, fracture, rash, etc. to right index finger, low back, left wrist, etc.)

Equipment, materials, and/or chemicals victim was using when the injury, illness, or event occurred.

Specific activity victim was performing when the injury, illness, or event occurred.

Was the victim(s) performing regular job duties at the time of the injury, illness, or event occurred?
(If not, please explain)

Please describe in your own words, anything you saw that was related to the injury, illness, or event.
(Please describe fully the events that resulted in the injury, illness, or event. Use additional pages if necessary)

Please describe in your own words, anything you heard that was related to the injury, illness, or event.
(Please describe fully the events that resulted in the injury, illness, or event. Use additional pages if necessary)

Is there anything you know that leads you to believe that this injury or illness did not happen at work?

I certify that this is an accurate statement in my own words, of the events I saw and/or heard about the injury, illness or accident of my coworker and events leading to such result

Signature	Date
Home Address	Telephone Number

Please return this form to the victim's supervisor when completed