Ashland School District Work Related Injury

Supervisor's Investigation Report

☐ New Report ☐ Update to Previous Report

Section 1 - Employee Information

Injured Employees Name: _____

Building & Job Title *(at time of injury)*: _____

Supervisors Name *(your name)*: _____

Date, time, and location of injury: _____

Section 2 - Injury Information

Is this injury related to their job and normal work duties? ☐ **Yes** ☐ **No**

Has there been medical treatment for the injury? ☐ **Yes** ☐ **No**

If yes, where did they receive treatment? _____

Will additional treatment be needed? ☐ **Yes** ☐ **No**

Do you have any concerns about the validity of the claim? ☐ **Yes** ☐ **No**

Were there any witnesses to the incident? ☐ **Yes** ☐ **No**

If yes, please provide the witness's name(s): _____

Is there video footage of the incident? ☐ **Yes** ☐ **No**

If yes, list the date that you sent it to the Human Resources Dept: _____

How do you plan to prevent recurrence? _____

_____

Section 3 - Work Attendance & Ability Information

Did the employee miss any days from work? ☐ **Yes** ☐ **No**

If yes, how many days did they miss? _____

If yes, what date did they return to work? _____

Does the employee have any work restrictions? ☐ **Yes** ☐ **No**

If yes, are you able to accommodate the restrictions? ☐ **Yes** ☐ **No**

Supervisor's Signature: **Date:**

***Return to Human Resources within 48 hours of Injury. Complete again with updated information if anything changes.**

Work Comp Coordinator Signature: **Date Received:**