SUPERVISOR'S INJURY REPORT

Within 24 hours of notice or knowledge of an injury (even if medical attention is not necessary), submit the following to Human Resources located in the Fort Building:

1. Completed **Employee's Report of Injury**
2. Completed **Supervisor's Injury Report**

Name of injured employee _____ Dept. _____

Date of injury ___/___/_____ Type of injury _____

Date you received notice, or had knowledge that the injury was work related ___/___/_____

Who informed you? _____

Person(s), other than those listed on the Employee's Report, who could provide further information about the incident:

Name/title/contact # _____

Name/title/contact # _____

Do you have any comments about the information on the Employee's Report?

_____

Do you have an opinion concerning the injury? _____

Do you feel this is a work-related compensable injury? ☐ Yes ☐ No

Why *or* Why not? _____

Was this an avoidable or unavoidable injury? If avoidable, how?

_____

_____

If avoidable, what action(s) have or are being taken? _____

_____

Had the person received training related to cause of injury? ☐ Yes ☐ No

Was safety equipment provided: Yes / No Used: Yes / No Explain: _____

Did the employee decline medical attention at the time of reporting? _____

Your Name and Title _____

Signature _____ **Date** ___/___/_____

Work/Cell Phone # (_____)_____-_____ **Normal working hours** _____