

## Supervisor's First Report of Employee Injury/Illness

This form is to be completed by the supervisor who first reports an injury or illness to the Office of Human Resources. Employees should complete this form if they are injured or become ill while working on the job. This form is to be completed by the supervisor who first reports an injury or illness to the Office of Human Resources. Employees should complete this form if they are injured or become ill while working on the job.

Position: \_\_\_\_\_ Employee's Name: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Phone: H: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Injury/Illness: \_\_\_\_\_ Time of Injury/Illness: \_\_\_\_\_  a.m. /  p.m. Date  
the employee reported the injury/illness to you: \_\_\_\_\_ to what date, what time did  
it occur: \_\_\_\_\_ Location Injury Occurred

Part of body involved (e.g. cut left hand, strained back, etc.): \_\_\_\_\_ Nature of Injury and part  
of body involved (e.g. cut left hand, strained back, etc.): \_\_\_\_\_

Describe how injury/illness occurred: \_\_\_\_\_  
\_\_\_\_\_

Names of witnesses: \_\_\_\_\_

Did the employee miss any work on the day of injury/illness? Yes  No

Did the employee see a doctor? Yes  No

Doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Did you report the injury/illness to the Office of Human Resources? Yes  No

Department: \_\_\_\_\_ Your Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

How did you find out about the injury/illness? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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