Supervisor's Report Of Employee Injury

To be completed by Supervisor

Employee Name _____Birthdate _____

Site _____Occupation _____

Time Employee began work _____ a.m. _____p.m.

Date of Injury _____ Time of Injury _____a.m. _____p.m.

Date Reported _____ Time reported _____a.m. _____p.m.

Accident Location _____

Type of Injury _____

Medical Facility where employee was treated: :

☐ US Healthworks
7793 Wren Avenue, Gilroy

☐ Kaiser On-The-Job
Santa Theresa Facility

☐ South Valley Family/Occupational
9460 No Name Uno, Gilroy

☐ Predesignated Physician (name)_____

Did injured leave work? _____ Date _____ Time _____a.m. _____p.m.

Has injured return to work? _____ Date _____ Time _____a.m. _____p.m.

Did employee receive treatment beyond first aid? ☐ Yes ☐ No

Describe how the accident occurred

_____

_____

_____

_____

Name of Witnesses _____ _____

What steps have been taken to prevent similar accidents?

_____

_____

_____

_____

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____