# SUPERVISOR'S EMPLOYEE INJURY REPORT

**This form is to be completed by supervisors upon interviewing employees and all witnesses for each occurrence of a "first-aid", "near miss" or an accident requiring medical attention. After completion, please forward this report to the Human Resource Department.**

Employee Name: Dept./Location:

Supervisor:

Nature of Injury or Illness:

Describe the accident: (Date of occurrence, place, time, what happened, what injury was sustained.)

Who was involved? (Name of witnesses, others who were involved)

How did it happen? (What equipment was involved, what was employee doing, etc.)

Why did this accident happen? (Could something have been done to prevent it, suggestions for correction)

Was medical attention required? (In-house treatment rendered or medical attention from Worker's Comp. Provider)

Supervisor's Signature Date **1002.91**