**Supervisor’s Report of Illness or Injury**

**Instructions:** This report must be completed by the supervisor or department head for faculty, staff or student involved in an incident or accident which results in personal injury. Each supervisor/department head is responsible to assure this form is fully completed, signed and returned to Human Resources at MS118 within 1-2 day following the incident/accident. Please keep a copy for your records.

**Immediate Supervisor’s Name (please print)**

**Injured Employee Name (please print)**

When did Injury occur? Date: ______________ Time: ______________

When did you first know of the injury? Date: ______________ Time: ______________

If the employee did not report this injury at the time it was incurred, give the reason for the delay.

_________________________________________________________________________________________________

Describe the exact location where the accident occurred.
_________________________________________________________________________________________________

Name of witness(es) : _______________________________________________________________________________

Describe fully how the accident occurred: _______________________________________________________________
_________________________________________________________________________________________________

Was this incident related to the employee’s regular occupation? If not, please explain: ___________________________
_________________________________________________________________________________________________

Describe the extent of injury to the employee, include all injured body parts: ________________________________
_________________________________________________________________________________________________

What steps were taken after the accident to provide care for the employee? (First aid, visit to Health Center, BEMCO, etc)
_________________________________________________________________________________________________

Describe all unsafe acts and unsafe conditions which contributed to the cause of the accident. _____________________
_________________________________________________________________________________________________

Describe corrective actions you have taken to prevent accidents of this type from recurring. _____________________
_________________________________________________________________________________________________

Did the injured employee finish the workday? ___ Yes ___ No (please, check one)

Did the injured employee work the next scheduled workday? ___ Yes ___ No (please, check one)

What are the employee’s regular days off? ______________________________________________________________

What are the employee’s hours scheduled to work? _______________________________________________________

**Immediate Supervisor’s signature**

**Dept Head’s signature**