HELPSIDE

SUPERVISOR'S INCIDENT REPORT OF WORK-RELATED INJURY

Company name:			Job title:		
Employee name:			Date hired:		
Address:			Social security number:		
City:	State:	Zip:	Number of dependent children under 18:		
Work phone:	Home phone:		Date of birth:	Married? ☐ Y ☐ N	Gender:

EMPLOYEE

Time shift began:	Incident date:	Incident time:	Date reported:	Time reported:
Witness:				Person notified:
Address of incident:				Safety equipment used:
Date of first medical treatment:	Date of next appointment:		Designated provider? ☐ Y ☐ N	Has this part been injured before? ☐ Y ☐ N
Doctor:	Phone number:		If no, explain:	If yes, explain:
Medical facility:				
Detailed description of incident:				

I authorize the release to my employer of all records relevant to my disability and my claim for disability or workers' compensation benefits, including but not limited to medical diagnosis, prognosis, treatment, and periods of hospitalization. It is understood that the company will use the information to verify my disability and determine my eligibility for appropriate benefits. This authorization applies to physicians and other health care providers, hospitals, and clinics, insurance companies and workers' compensation carriers, and organizations administering benefit programs. This authorization will remain in effect throughout my claim for workers' compensation benefits. A photocopy of this authorization will be as valid as the original.

Employee signature:	Date:

SUPERVISOR

Has employee lost time from work? ☐ Y ☐ N	What was the cause of the injury? (please check one) ☐ Operating without authority/training; disobeying safety rules ☐ Failure to utilize safety/personal protection equipment List equipment: _____ ☐ Equipment malfunction List equipment: _____ ☐ Other: _____ Explain: _____
Date and time left work:	
Date and time returned to work:	
Employee drug screen performed? ☐ Y ☐ N	
Hourly pay rate:	
Detailed description of incident:	
What corrective action has been/will be taken to prevent recurrence?	

Supervisor signature:	Supervisor name:	Date: