

**SUPERVISOR’S REPORT OF INJURY**

Fire District:

Date of Injury: Time of Injury:

Injured Worker’s Name:

Home Address:

City: State: Zip Code:

Telephone Number: Social Security Number:

Employee Date of Birth: Email:

🞏Male 🞏Female 🞏 Married 🞏Single # Dependents Avg Weekly Wage

Date of Hire Last Day Employee Worked

Who reported the accident:

When was injury/illness reported:

Type of injury:

What was the employee doing when injury occurred:

Any Witnesses: 🞏Yes 🞏 No IF YES, Who

Please describe the accident. (Include events leading up to the injury and any objects or substance involved.)

Did employee seek medical attention: 🞏 Yes 🞏 No

Could this injury have been prevented: 🞏 YES 🞏 No Please Explain:

What did anyone do, or fail to do that caused the accident/injury:

Was this injury the result of unsafe working condition(s): 🞏 YES 🞏 No Please Explain:

What action(s) have been taken to prevent injuries from occurring again:

Have you any reason to believe this was NOT an on-the-job injury 🞏 YES 🞏 No

If Yes, Please Explain in detail:

Is the employee alleging a Workers’ Compensation Claim? 🞏 YES 🞏 No

Has the employee missed any time from work resulting from this injury? 🞏 YES 🞏 No

If Yes, Please list the dates of complete shifts the employee missed, but would have normally worked:

Has the employee returned to work? 🞏 YES 🞏 No If Yes, Date of Return:

I understand that falsification of this statement, or any misrepresented information contained in this statement, can result in disciplinary action.

Supervisor Signature Date