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|--|---|---|--|---|--|-------------------------------------|
| Supervisor's Report of Industrial Injury   |   | <b>Modified Duty is Available</b>           |  | Risk Mgmt Use Only                          |  |                                     |
| COMPLETE AND FAX THIS REPORT TO RISK MANAGEMENT WITHIN 24 HOURS OF ACCIDENT                            |   |   |  | OSHA Case # _____                           |  |                                     |
| -----<br><i>FATALITIES MUST BE REPORTED WITHIN 4 HOURS</i>   |   |   |  | Work Comp # _____                           |  |                                     |
| LAST NAME  |   | FIRST NAME                                  | MI                                       | SOCIAL SECURITY NUMBER                      |  | BIRTH DATE                          |
| STREET ADDRESS (NUMBER & STREET)   |   |   | CITY                                     | STATE                                       | ZIP  | HOME TELEPHONE                      |
| MAILING ADDRESS (NUMBER & STREET)  |   |   | CITY                                     | STATE                                       | ZIP  |                                     |
| SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE                                     |   | MARITAL STATUS                              |  |   |  |                                     |
| EMPLOYER'S NAME  |   |   |  | *DEPT. #                                    |  |                                     |
| STREET (NUMBER & STREET)   |   |   | CITY                                     | STATE                                       | ZIP  | WORK TELEPHONE                      |
| Date of Injury   | Time of Injury                                | Date Employer Notified of Injury            |  | Date Employee Left Work                     |  | Date Returned to Work               |
| / /  | am / pm                                       | / /   |  | / /   |  | / /                                 |
| Employee's Occupation (Job Title) When Injured   |   |   |  |   |  |                                     |
| Address or Location of Accident  |   |   | City                                     | County                                      | State  | Zip Code                            |
| On Employer Premises?  | Nature of Injury (Scratch, Cut, Bruise, etc.) |   |  | Fatal?                                      | Part of Body Injured   |                                     |
| Will Treatment Be Sought? If Yes, Where?   |   |   |  |   |  |                                     |
| What was Employee Doing When Accident Occurred?<br>(Loading Truck, Walking Down Stairs, etc.)          |   |   |  | Where Did Accident Happen?                  |  |                                     |
| Specify Machine, Tool, Substance or Object Most Closely Connected With Accident                        |   |   |  | Were Others Injured in This Accident?       |  |                                     |
| How Did Accident Happen? (State All Details. Use Reverse if Needed)                                    |   |   |  |   |  |                                     |
| If Validity of Claim is Doubted, State Reason:   |   |   |  |   |  |                                     |
| Was Personal Protective Equipment Being Worn? <input type="checkbox"/> YES <input type="checkbox"/> NO |   |   |  |   |  |                                     |
| If Yes, What type? (Check One or More Items Below)   |   |   |  |   |  |                                     |
| <input type="checkbox"/> Protective Clothing   | <input type="checkbox"/> Foot Protection      | <input type="checkbox"/> Eye Protection     | <input type="checkbox"/> Head Protection | <input type="checkbox"/> Seat Belts         | <input type="checkbox"/> Hearing Protection  | <input type="checkbox"/> Respirator |
|  |   |   |  | <input type="checkbox"/> Back Support Belt  | Other (explain): _____   |                                     |
| If Another Person Not in County Employ Caused Accident, Give Name and Address                          |   |   |  |   |  |                                     |
| Length of Time Employee at Present Job   |   | Work Hours                                  | Scheduled Day Per Week                   |   | Was Employee On Overtime When Injury Occurred?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                                     |
| Witness Information: Name, Address, City, State, Zip   |   |   |  | Area Code, Telephone Number of Each Witness |  |                                     |
| If a Diagram of Accident Would Help, Please Complete Same on Blank Piece of Paper and Attach           |   |   |  |   |  |                                     |
| Employment Category  | <input type="checkbox"/> Regular, Full-Time   | <input type="checkbox"/> Regular, Part-Time | <input type="checkbox"/> Temp            | <input type="checkbox"/> Seasonal           | <input type="checkbox"/> Volunteer   |                                     |
| Supervisor Print Name  | Sign Name                                     | Phone No                                    |  | Date  | Title  |                                     |

| Employee Print Name | Sign Name | Office Direct Line # | Date | Title |
|---------------------|-----------|----------------------|------|-------|
|---------------------|-----------|----------------------|------|-------|