SUPERVISOR'S INVESTIGATION REPORT
Of Employee Work Injury

Name of Injured Employee ______________________ Date ______________________

Job Title and Department ______________________

Date and time of Injury ______________________ Type of Injury ______________________

Medical Facility ______________________

What was the employee doing when injured? Where in the facility/job site did the accident happen? If the incident was witnessed, list names

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Describe what happened: ______________________

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What corrective steps will be taken (or could be taken) to prevent recurrence?

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Was the employee working at designated job? ☐ Yes ☐ No

Is there modified duty available for the injured worker? ☐ Yes ☐ No

Has the injured employee returned to work? ☐ Yes ☐ No
If so, what date? ___________________

Supervisor's Signature ______________________ Date __________

Workers' Compensation Representative ______________________ Date __________

Comments: ______________________

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Return completed report within 24 hours of the accident to the workers' compensation representative.