SUPERVISOR'S REPORT OF INJURY OR ILLNESS

Instructions: Supervisors shall use this form to report all reported work-related injuries, illnesses, or first aid events (which could have caused an injury or illness) – no matter how minor. This helps to identify and correct hazards before they cause serious injuries. This form shall be completed by Supervisors upon notice by the employee of a reported on the job injury, illness or "incident".

ALL ITEMS: MUST BE ANSWERED FULLY

WARNING: "WORKER'S COMPENSATION INSURANCE FRAUD IS A CRIME PUNISHABLE BY LAW"

EMPLOYEE INFORMATION

Type of work related incident reported: ☐ Injury ☐ Illness ☐ First Aid			
Location:	State:	Department:	Telephone: ( )
Employee Name:	Date of Birth: / /	Employee Number:	
Address:	City:	State:	Zip:
Social Security:	Married: ☐ Yes ☐ No	Sex: ☐ Male ☐ Female	Age:
Job Title:		Length of Service with Company (Years):	
Hourly Wage Rate:		Job Being Performed at Time of Injury:	
Date of incident:	Time of incident:	Other Employees involved in incident: ☐ Yes ☐ No	

Release of Medical Information

I certify that the above information is true to the best of my knowledge and I authorize the release to my employer and to LWP Claims Solutions, Inc., 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 of 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

INCIDENT DETAILS

Date of Incident: / /	Time of Incident: ☐ AM ☐ PM		Date Reported: / /
Shift: ☐ Graveyard ☐ Days ☐ Afternoon ☐ Other:	Was Employee on Overtime: ☐ Yes ☐ No		
Incident Location (specific area):	Time Shift Commenced on employer premises? ☐ Yes ☐ No		
Witness (es) to Incident:			
Did Employee lost time due to the injury? ☐ Yes ☐ No	First Aid Given? ☐ Yes ☐ No		
Date worker left work: / /	Time Worker left work:	Date worker returned to work: / /	
Completed if Applicable (if Medical Attention is sought, complete State Form)			
Name of Medical Facility:	Doctor Name:		
Follow up appointment scheduled? ☐ Yes ☐ No	If Yes then Date and Time of next follow up: / /		
Was time off authorized by the physician? ☐ Yes ☐ No	If Yes then how many days?		

Treatment given:				
	☐ None	☐ Cast	☐ Irrigation	☐ Sutures
	☐ Brace	☐ Ace Bandage	☐ Prescription	☐ Removal of Foreign Object
	☐ Tetanus Shot		☐ Other:	

PART OF BODY INJURED – MARK ALL THAT APPLY

☐ Head	☐ Eye	☐ Left	☐ Right	☐ Hip	☐ Left	☐ Right	☐ Foot	☐ Left	☐ Right
☐ Face	☐ Elbow	☐ Left	☐ Right	☐ Thigh	☐ Left	☐ Right	☐ Ribs	☐ Left	☐ Right
☐ Nose	☐ Forearm	☐ Left	☐ Right	☐ Knee	☐ Left	☐ Right	☐ Toe	☐ Left	☐ Right
☐ Neck	☐ Hand	☐ Left	☐ Right	☐ Leg	☐ Left	☐ Right	☐ Abdomen		☐ Trunk
☐ Skin	☐ Shoulder	☐ Left	☐ Right	☐ Ankle	☐ Left	☐ Right	☐ Other:		
☐ Chest	☐ Finger (Identify):			☐ Back	☐ Upper	☐ Lower			

SUPERVISOR

NATURE OF INJURY – MARK ALL THAT APPLY

☐ Abrasion	☐ Fracture			☐ Foreign Object	☐ No Physical Injury
☐ Laceration	☐ Dislocation			☐ Inflammation	☐ Concussion
☐ Puncture	☐ Dermatitis			☐ Inhalation	☐ Electric Shock
☐ Amputation	☐ Poisoning:	☐ Chemical	☐ General	☐ Sprain	☐ Respiratory Disorders
☐ Crushing	☐ Burn:	☐ Chemical	☐ Heat	☐ Strain	☐ Mental Disorder
☐ Hernia	☐ Exposure:	☐ Cold	☐ Heat	☐ Fatality	☐ Cancer
☐ All Other *(describe)*:					

INVESTIGATION

Date of Investigation: / /		Person(s) Making Investigation:	
Employee's supervisor (print name):		Supervisor's Phone: ( )	
Who was immediately in charge at the time of injury:			
Was employee task trained?	☐ Yes ☐ No	If Yes, explain:	
Were Safety Codes/Rules Violated?	☐ Yes ☐ No	If Yes, explain:	
Equipment Involved:	Type:	Model:	Manufacturer:

CAUSE OF INJURY – MARK ALL THAT APPLY

☐ Chemicals	☐ Building/Structures			☐ Hand Tools – Non Power	☐ Foreign Matter (Body)
☐ Vehicles	☐ Infectious Agents			☐ Hand Tools – Power	☐ Sharp Objects
☐ Conveyers	☐ Furniture/Fixtures			☐ Flame/Fire/Smoke	☐ Flying Objects
☐ Machines	☐ Falling/Flying Objects			☐ Ladders	☐ Animal/Insect
☐ Airplane	☐ Electrical	☐ High	☐ Low	☐ Stepping On, NOC.	☐ Slip/Trip/Fall
☐ Motor, NOC	☐ Object/Substance	☐ Hot	☐ Cold	☐ Noise	☐ Cumulative, NOC
☐ Other – Miscellaneous, NOC:					

CAUSE OF INCIDENT – MARK AND EXPLAIN ALL THAT APPLY

☐ Horseplay	☐ Improper Material Handling	☐ Equipment Failure	☐ Excessive Speed
☐ Fatigue	☐ Wet Slippery Uneven Surface	☐ Lack of Attention	☐ Procedure Failure
☐ Poor Housekeeping		☐ Other:	

ANALYSIS

Description of Incident:

STEPS TAKEN TO PREVENT SIMILAR OCCURRENCE – MARK AND EXPLAIN ALL THAT APPLY

☐ Reinstruction of Employee Involved	☐ Formal Disciplinary Action
☐ Remainder Instruction of all Employees	☐ Installation of Guard Device
☐ Personal Protective Equipment Required	☐ Counseling of Employee

Comments:

Supervisor Signature: ______________________ Date: ______________