SUPERVISOR'S REPORT

EMPLOYER:	
NAME OF INJURED:	
DATE OF INJURY:	
Supervisor/Title (Completing this form):	
Home Address:	Phone: ()
(Street)	(City, State, Zip code) Phone: ()
Your Current Job Title:	Length of time in position:
Length of time with current employer:	
Positions held (if different than above)	
INJURY INFORMATION:	
Nature of Injury, Part of Body affected:	
	:
Witness(es):	Statement taken? (Y/N)
Any reason to question the accident, if so v	why?
Safety training provided to the injured?	Yes No
Corrective actions taken to prevent recu	urrence:
What Physician did the Injured choose	from the Panel
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	om work if so how long?s? If so, what are they
	so was work provided?
Please check the list below if completed	
First Report	Statement of the Injured Designated Physician Form
Physician Appt for Injured	Job Analysis(if restrictions are given)
Supervisor Signature	Date
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