SUPERVISOR'S INVESTIGATION REPORT

Name of Injured Employee:	Date:
Job Title and Department:	
Date and Time Of Injury:	Type of Injury:
Medical Treatment Center:	

What was the employee doing when injured? Where in the facility / job site did the accident happen?

Describe what happened:

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

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

Reviewed by Workers' Compensation Coordinator Date

Comments:

Return completed form within 24 hours of the accident to Laura Graf.

Form completed by the supervisor of the injured employee and saved in the injured employee's file

EMC. Insurance Companies