SOUTHWESTERN COLLEGE

Supervisor's Report of Employee Illness/Injury

TO BE COMPLETED BY SUPERVISOR OR DESIGNEE ONLY Date of Report:_____

Name of Injured Employee:_____ Site:_____

Job Title:_____ Hrs/day:_____ Days/wk:_____

Where Did Accident or Exposure Occur?: On Employer's Premises?

_____ ☐ Yes ☐ No

Specific Injury/Illness and Part of Body Affected (i.e. twisted ankle on right foot, second degree burns on left arm, etc.):

_____

Equipment, Materials or Chemicals Employee Was Using When Event or Exposure Occurred:
(i.e. projector, mop, vacuum, Round-Up, paper cutter)

_____

Specific Activity Employee Was Performing When Event or Exposure Occurred (i.e. moving boxes, mopping floor):

_____

Completely Describe Location of Incident (including lighting, walking surface, weather, measurements and any other condition that could have contributed to or prevented the incident):

_____

Describe Shoes, Physical Appearance or Any Other Characteristic that Would Contribute to Understanding How the Accident/Injury Occurred:

_____

Describe Demeanor of Person Involved and Include Statements Made as "Excited Utterances":

_____

How Injury/Illness Occurred: **Describe sequence of events and specific object or exposure that caused injury/illness.** (i.e. Stepped back and slipped. As he fell, he twisted back). If applicable, include details of location (weather, lighting, walking surface), physical appearance (type of shoes or clothing) and/or demeanor of injured employee (upset, clowning around). Use separate sheet if necessary. State facts, contributing factors, cite witnesses and support evidence.

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Was Doctor Seen? ☐ Yes ☐ No If Hospitalized, Name and Address of Hospital
(If yes, name and address of Doctor)

First Aid Applied? ☐ Yes ☐ No
(Please be specific)

Witnesses (use separate sheet if necessary):

Date of Injury/Illness:_____ Time:_____ ☐ a.m. ☐ p.m.

Time Employee Began Work on Day of Injury/Illness:_____ ☐ a.m. ☐ p.m.

Was Injury the Result of Anyone Other Than Employee? ☐ Yes ☐ No

If Yes, Explain:

Has Employee Returned to Work?
☐ No ☐ Yes, Date Returned:_____

Employee Status:
☐ Regular Full Time ☐ Part Time ☐ Sub

Have Any Steps Been Taken to Prevent Similar Accidents? ☐ Yes ☐ No

Please Describe:

If There Is a Safety Issue, Please Describe:

_____ _____ _____
Supervisor Name Supervisor's Signature Date