



SUPERVISOR'S INCIDENT REPORT OF WORK-RELATED INJURY OR ILLNESS

PO Box 308
American Fork, UT 84003
Phone: (801) 443-1090
Toll Free: 1-800-748-5102
Fax: (801) 841-3538

Client Company			Job Title		
Employee			Date Hired		
Address			Social Security #		
City	State	Zip Code	# of Dependent Children Under 18		
Work Phone #	Home Phone #		Date of Birth	Married? <input type="checkbox"/> Y <input type="checkbox"/> N	Gender? <input type="checkbox"/> M <input type="checkbox"/> F

Incident/Injury Details

EMPLOYEE	Time Shift Began	Incident Date	Incident Time	Date Reported	Time Reported	
	Witness			Person Notified		
	Address of Incident			Safety Equipment Used		
	Date of 1 st Medical Treatment	Date of Next Appointment		Designated Provider? <input type="checkbox"/> Y <input type="checkbox"/> N	Has this body part been injured before? <input type="checkbox"/> Y <input type="checkbox"/> N	
	Doctor	Phone #		If No, Explain:	If Yes, Explain:	
	Medical Facility					
	Description of Incident (in Detail)					
	I authorize the release to my employer of 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 for appropriate benefits. This authorization applies to physicians and other health care providers, hospitals, and clinics, insurance companies and worker's compensation carriers, and organizations administering benefit programs. This authorization will remain in effect throughout my claim for work comp benefits. A photocopy of this authorization will be as valid as the original.					
	Employee Signature: _____			Date: _____		

SUPERVISOR	Has Employee Lost Time from Work? <input type="checkbox"/> Y <input type="checkbox"/> N	What was the cause of the injury? (Please check one.) <input type="checkbox"/> Operating without authority/training; disobeying safety rules <input type="checkbox"/> Failure to utilize safety/personal protection equipment (List equipment) _____ <input type="checkbox"/> Equipment malfunction (List equipment) _____ <input type="checkbox"/> Other (Explain) _____
	Date & Time Left Work	
	Date & Time Returned to Work	
	Employee Drug Screen Performed? <input type="checkbox"/> Y <input type="checkbox"/> N	
	Hourly Wage Rate	
	Description of Incident (in Detail)	
What corrective action has been/will be taken to prevent recurrence?		
Supervisor's Signature	Printed Name	Date