SUPERVISOR'S REPORT OF INJURY

Instructions: Please fill out completely and as detailed as possible. Sign and email to Drew Reynolds areynolds@4wp.com & Stephanie Alvarado salvarado@explorerprocomp.com on the day of injury, or day reported.

Employee Name	Location Site Code	Home Phone Number or Cell

Date of Birth	Home Address	City	State	Zip	Job Title

Employee's Scheduled Work Week When Injured (Days and Times)	

Date of Injury	Time of Injury	Date Reported	Work Start Time

Date of next appointment	To whom was the injury reported?	Name any witnesses (Attach statements if available)

Did the doctor place employee on restricted work duties?	☐ Yes ☐ No	If so, can you accommodate the restrictions?	☐ Yes ☐ No	Did the doctor place employee off work?	☐ Yes ☐ No

Name of Clinic	Doctor	Address	Is this the Medical Provider Network clinic?
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Injured employee's statement of what happened. (Identify circumstances and equipment involved)

What equipment or material actually caused the injury? Example: cutting blade, grinder, forklift, floor

List the body part(s) affected by the injury and the type of injury: Example: Right finger laceration

Indentify unsafe act or unsafe conditions that caused the injury

Identify the action being taken to prevent reoccurrence of the same or similar injury

Physical Location where the injury occurred: Example: Shop, Warehouse, Front of building

Comments

SUPERVISOR - PRINT NAME	SUPERVISOR - SIGN NAME	DATE