Supervisor's First Report of Employee Injury/Illness

To be completed by a supervisor following any employee injury, regardless of whether or not the employee leaves work or sees a doctor. Form must be submitted to the Facilities Services/Risk Management Office **within 24 hours of injury.**

Employee's Name:_____ Position:_____

Social Security #:_____ Phone: H)_____

Address: _____

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

On this date, what time did the employee begin work? _____ a.m./p.m.

Location Injury Occurred:_____

Nature of Injury and part of body involved (e.g. cut left hand, strained back, etc.): _____

_____

_____

Describe how injury occurred:_____

_____

Names of witnesses:_____

Did the employee leave work on the day of injury/Illness? **Yes** ☐ **No** ☐

Did the employee see a doctor?* **Yes** ☐ **No** ☐

Doctor's name:_____ Phone:_____

Did you provide a Claim Form (DWC Form 1)?** **Yes** ☐ **No** ☐

Your Name:_____ Department:_____

Date and time you found out about the injury/illness:_____ a.m./p.m.

How did you find out about the injury/illness? _____

_____

_____

Comments:_____

_____ _____

Supervisor's Signature Date

***Unless the employee has pre-designated their personal physician, the initial injury evaluation should be directed to Kaiser Industrial Medicine or WorkHealth Occupational Medicine. (See RMS Form 4 for further information) or the Emergency Room at Queen of the Valley Hospital, depending on the severity of the injury.**

****If the employee left work or saw a doctor, THEY MUST BE PROVIDED WITH A CLAIM FORM FOR WORKER'S COMPENSATION BENEFITS (DWC-1) within 24 hours of injury.**