WCD 201 – Supervisor's Report of Injury

Case or File No.________________________

Instructions: Complete this report within 48 hours after occurrence of injury. Forward to Workers' Compensation Division. If complete details are not available, check "Preliminary" and submit a supplemental report later.

SUPERVISOR'S REPORT OF AN INJURY ☐ PRELIMINARY ☐ SUPPLEMENTAL

DEPARTMENT	UNIT OR DIVISION	☐ FIRST AIDE ☐ LOST TIME ☐ DEATH

INJURED'S LAST NAME	FIRST	MIDDLE	TITLE

AGE	☐ MALE ☐ FEMALE	LENGTH OF EMPLOYMENT IN DEPT	ON PRESENT ASSIGNMENT	EMPLOYEE'S S.S. NO. (IF APPLICABLE)

DATE OF INJURY OR INITIAL DIANOSIS OF OCCUPATIONAL ILLNESS	TIME AM ☐ PM ☐
PLACE OF ACCIDENT OR EXPOSURE	ON EMPLOYER'S PREMISES (Y OR N)
DID EMPLOYEE DIE?	WITNESS (NAME AND TITLE IF NON-EMPLOYEE INCLUDE ADDRESS)

DESCRIBE ACCIDENT IN DETAIL
NAME AND ADDRESS OF PHYSICIAN
IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL
INJURED PART OF BODY
NATURE OF INJURY
ACCIDENT TYPE
MAJOR CAUSE – UNSAFE ACT OR UNSAFE CONDITION
CONTRIBUTING CAUSE – UNSAFE ACT OR UNSAFE CONDITION

INDICATE BELOW WHAT YOU HAVE DONE TO PREVENT SIMILAR ACCIDENTS		THIS SPACE FOR DEPT. SAFETY COORDINATORS REMARKS AND RECOMMENDATIONS
SIGNATURE OF SUPERVISOR	DATE	SIGNATURE OF SAFETY COORDINATOR
TITLE	TELEPHONE NO.	DATE