

**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		<input type="checkbox"/> FIRST AIDE <input type="checkbox"/> LOST TIME <input type="checkbox"/> DEATH	
INJURED’S LAST NAME		FIRST	MIDDLE	TITLE	
AGE	<input type="checkbox"/> MALE <input type="checkbox"/> 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	