SUPERVISOR'S REPORT OF INJURY

Fax/Email within 24 hours of injury
Fax: 941.866.2476 Email: Claims@WorksiteEmployee.com

EMPLOYER INFORMATION

Client Number:	Company Name:
Contact Person:	

EMPLOYEE INFORMATION

Employee Name:	Daytime Phone:

ACCIDENT INFORMATION

Date of Accident: ____________________ Time of Accident: ____________________

Where did the accident occur? ____________________

Describe the work being done and how the accident occurred: ____________________

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Will the employee be paid in full for the day of the injury? ❍ No ❍ Yes

Did the employee return to work? ❍ No ❍ Yes If yes, date returned: ____________________

Were there witnesses to the accident? ❍ No ❍ Yes If yes, please list witness names below.

Witness name(s): ____________________

INJURY INFORMATION

Describe the type of injury in detail (please be specific): ____________________

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Please list any pre-existing conditions that may apply: ____________________

Is there any doubt or question as to the validity of the injury? ❍ No ❍ Yes

TREATMENT FACILITY INFORMATION

Name:	Phone:
Address:	

Please provide all notes provided by treating facility

REFUSAL OF TREATMENT

Did the employee refuse treatment? ❍ No ❍ Yes

Did the employee refuse a drug screen? ❍ No ❍ Yes

Employee Signature: ____________________ Date: ____________________

Supervisor Signature: ____________________ Date: ____________________