Supervisor's Report of Injury

Employee Name: _____ SS#:_____

Employee Job Title / Position: _____ DOB: _____

Client Company: _____

Supervisor's Name: _____

Date/Time of Accident: _____ Location: _____

Did Employee seek medical attention: _____

If yes where: _____

Did Employee complete a drug screen: _____ Where:_____

Name of Witnesses: _____

Statement of how injury occurred: _____

_____

_____

Part of Body Affected: _____

Type of Injury: _____

Print Name: _____ Date: _____

Signature: _____ Phone #: _____

Fax To (904)-731-0059