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