

Form 1

**SUPERVISOR'S FIRST REPORT OF INJURY**

(This report is to be completed by the Supervisor and forwarded to the Database/Risk Manager immediately upon the employee being injured).

**1. EMPLOYEE INFORMATION:**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Marital Status: \_\_\_\_\_ DOB: \_\_\_\_\_

Department: \_\_\_\_\_ Phone # \_\_\_\_\_

Employee Status: F/T \_\_\_\_\_ P/T \_\_\_\_\_ Prisoner \_\_\_\_\_ Volunteer \_\_\_\_\_ Other \_\_\_\_\_

**2. INJURY INFORMATION:**

Date of Injury: \_\_\_\_\_ TIME OF INJURY: \_\_\_\_\_ AM/PM

Last Date worked: (if employee has not returned to work): \_\_\_\_\_

Location of accident: \_\_\_\_\_ County Property: yes \_\_\_ no \_\_\_

Date employer notified: \_\_\_\_\_ Individual notified: \_\_\_\_\_

Witness Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Phone #'s: Work \_\_\_\_\_ Home: \_\_\_\_\_

**3. INJURY DETAILS:**

(a) Describe the nature of injury (include body parts(s) affected; amputation of right index finger at 2d joint, fracture of arm below or above elbow, burns, etc. If necessary continue on a separate sheet of paper:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(b) Describe employees activities when injury occurred (include name of other individuals involved, tools, machinery, chemicals or unnatural motions(s) of employee- Give as much detail as possible) Continue in Item 6 or on a separate page if necessary):

\_\_\_\_\_

**4. Safety Equipment (PPE):**

Was appropriate Safety equipment (PPE) used? (i.e., gloves, aprons, glasses, etc.) Yes \_\_\_\_\_  
No \_\_\_\_\_

Was appropriate PPE provided? Yes \_\_\_ No \_\_\_ if no, why wasn't the PPE  
Provided? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(The following questions apply only to the Detention Center, EMS, Fire District, Codes Enforcement, Environmental Services, Sheriff's Department and Building's Maintenance!) Did this injury occur as result of an Infection Control Exposure Incident; either blood borne or airborne? Yes \_\_\_ No \_\_\_

Was an Infection Control Exposure Incident Report filed with the Department's Designated Officer in accordance with the Infection Control Plan? Yes \_\_\_ No \_\_\_

**5. Medical Information/Treatment:**

Physician's Name and Address:

\_\_\_\_\_  
\_\_\_\_\_

Was the employee treated at a hospital? Yes \_\_\_ No \_\_\_  
Which Hospital (Name and Address)

\_\_\_\_\_  
\_\_\_\_\_

Was the employee hospitalized? Yes \_\_\_ No \_\_\_

Was the employee treated: Emergency Room Yes \_\_\_ No \_\_\_  
Out-patient Yes \_\_\_ No \_\_\_  
In-house treatment Yes \_\_\_ No \_\_\_  
First Aid: Yes \_\_\_ No \_\_\_

Was the employee transported by an EMS Service or a Volunteer Rescue Squad as a result of the accident? Yes \_\_\_ No \_\_\_ if so what service or Rescue Squad transported the employee? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**6. Remarks or information continue from item 3:**

\_\_\_\_\_  
\_\_\_\_\_

Prepared by: \_\_\_\_\_ Date \_\_\_\_\_