LABBB Collaborative

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

EMPLOYEE NAME:________________________________ S.S.N:_____________________

EMPLOYEE ADDRESS:____

TELEPHONE NU:(H)_______________ (C) __________________ (W) _________________

MARITAL STATUS:________________ DATE OF HIRE:____________________________

DEPARTMENT:____________________ OCCUPATION:_____________________________

DATE OF BIRTH:_______ SEX (M or F):____ AVERAGE WEEKLY WAGE:_____________

NUMBER OF DEPENDENTS:_____________ DATE OF INJURY:______________________

DESCRIPTION OF INJURY:____

LOCATION ACCIDENT OCCURRED:____

WITNESS:_______________________WITNESS ADDRESS:_________________________

TELEPHONE NU:____

TO WHOM WAS INJURY REPORTED TO/THEIR POSITION:__________________________

DID EMPLOYEE LOSE TIME FROM WORK? (Y or N)_____

WAS MEDICAL TREATMENT SOUGHT? (Y or N)_____Tax ID Number:_________________

MEDICAL FACILITY:____

DATE INJURY WAS REPORTED:____

INJURY:______________________________**BODY PART:**__________________________

RETURN TO WORK DATE:____

*******Supervisor's Complete Below*******

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED? WHY?

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CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY:_______________

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REMARKS:____

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Investigated By:_____________________________________ **Date:**____________________

Reviewed By:_______________________________________ **Date:**____________________

☐ School Nurse ☐ Supervisor