# Supervisor's First Report of Employee Injury/Illness

To be completed by a supervisor following any employee injury, regardless of whether or not the employee leaves work or sees a doctor. Form must be submitted to the Facilities Services/Risk Management Office **within 24 hours of injury.**

Type of Incident (Please Check One):

☐ INJURY ☐ ILLNESS ☐ INCIDENT ONLY (no medical care required)

Employee's Name: _____ Position: _____

Social Security #: _____ Employee ID: _____

Address: _____

E-mail: _____ Phone: _____

---

Date of Injury/Illness: _____ Time of Injury/Illness: _____ a.m./p.m.

On this date, what time did the employee begin work? _____ a.m./p.m.

Location Injury Occurred: _____

Nature of Injury and part of body involved (e.g. cut left hand, strained low back etc.): _____

_____

Describe how injury/illness occurred (Who/What/When/Where/Why): _____

_____

Names/phone # of witnesses: _____

**Did the employee leave work on the day of injury/Illness?** ☐ **Yes** ☐ **No**

**Has injured employee returned to work? If yes, provide date:** ☐ **Yes** _____ ☐ **No**

**Did the employee see a doctor?*** ☐ **Yes** ☐ **No**

Medical Provider: _____ Phone: _____

**Did you provide a Claim Form (DWC Form 1)?*** ☐ **Yes** ☐ **No**

**Corrective Action Required? (If yes, explain):** _____

**Was the injury preventable? (If yes, explain):**

---

Your Name (Supervisor): _____ Department: _____

Date and time you found out about the injury/illness: _____ a.m./p.m.

How did you find out about the injury/illness? _____

_____

Comments: _____

_____ _____

Supervisor's Signature Date

***Unless the employee has pre-designated their personal physician, the initial injury evaluation should be directed to Kaiser Occupational Medicine (Kaiser Members only) or Wine Country Occupational Medicine. (See RMS Form 4 for further information) or the Emergency Room at Queen of the Valley Hospital, depending on the severity of the injury.**

****If the employee left work or saw a doctor, THEY MUST BE PROVIDED WITH A CLAIM FORM FOR WORKER'S COMPENSATION BENEFITS (DWC-1) within 24 hours of injury.**

RMS Form 1, 02/01