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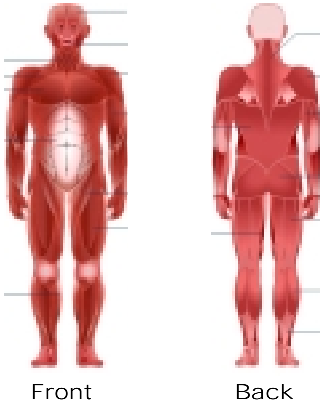
simplifying employment

SUPERVISOR'S REPORT OF INJURY/ILLNESS

*Complete within 24 hours of injury and fax to CoStaff at 248.**671.0802***

Supervisor Name		Social Security Number	
Supervisor Address, City, State, Zip			
Supervisor Phone		Date of Birth	
Injured Employee Name			
Date of Injury		Time of Injury	
Location of Injury		Time Employee Began Work	☐ AM ☐ PM
Work-Site Employer Name			

Mark areas of injury below.



CAUSE	TYPE OF INJURY
☐ Slip and fall	☐ Scrape / Bruise
☐ Struck by equipment	☐ Sprain / Strain
☐ Lifting or moving	☐ Puncture wound
☐ Caught (in, on or between)	☐ Cut / Laceration
☐ Puncture	☐ Concussion
☐ Object in eye (☐ Left ☐ Right)	☐ Bite
☐ Repetitive / Overuse	☐ Chemical Burn/Rash/Breathing Issues
☐ Other:	☐ Other:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Describe details of the injury and how it occurred.

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What date did the employee notify you of the injury? ______________________________

Employee referred to: ☐ Clinic ☐ Hospital ☐ Employee refused medical attention.
If applicable, indicate name of Clinic/Hospital: ______________________________

Last day worked ______________
Has employee returned to work? ☐ Yes ☐ No If yes, date of return ______________

Name of others who may have witnessed the injury:

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Thank you for assisting us with this matter. Please sign and date this form.

Supervisor Signature ______________________________ Date ______________