

### Attachment-D Supervisor's Injury Report

This is an official document to be initiated by the employee's supervisor. Please answer all questions completely.

**This report must be forwarded to FA Industrial Services, Inc. Risk Control Department within 8 hours of the injury.**

Name of injured employee \_\_\_\_\_

Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

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

Job Title \_\_\_\_\_ Date of hire \_\_\_\_\_

Date of Incident \_\_\_\_\_ Time \_\_\_\_\_ Time reported \_\_\_\_\_

Reported to whom? \_\_\_\_\_

Project Name \_\_\_\_\_ Project No. \_\_\_\_\_

Job assignment at time of incident \_\_\_\_\_

Phase \_\_\_\_\_ Task \_\_\_\_\_ Subtask \_\_\_\_\_

Time shift began: \_\_\_\_\_

Did the employee leave the work area?  YES  NO If YES, When? \_\_\_\_\_

Doctor/Hospital name \_\_\_\_\_

Address \_\_\_\_\_

Witness name(s) \_\_\_\_\_

Statement attached?  YES  NO

Nature of injury \_\_\_\_\_

Exact body part(s) affected \_\_\_\_\_

Medical attention:  None  First Aid on site  Doctor's office  ER  Hospital

Has employee returned to work?  YES  NO If Yes, when? \_\_\_\_\_

Incident type:  First Aid  Recordable, No lost/restricted workdays  Lost Workdays

Restricted Activity

Days away from work \_\_\_\_\_ Days restricted work \_\_\_\_\_ Total days charged \_\_\_\_\_

Describe incident: \_\_\_\_\_

**Attachment-D Supervisor's Injury Report (continued)**

What unsafe physical condition(s) or unsafe act(s) caused the incident? \_\_\_\_\_

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

What corrective action has been taken to prevent recurrence? \_\_\_\_\_

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

Supervisor \_\_\_\_\_  
Print Signature Date

Project Manager \_\_\_\_\_  
Print Signature Date

**Manager Comments:** Comments on incident and corrective action: \_\_\_\_\_

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

**Safety and Health Comments:** Corrective action taken?  YES  NO

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

\_\_\_\_\_  
Print Signature Date