

# AdminSure, Inc.

## Supervisor's Report of Injury or Illness (Complete for All Employee Reported Injuries)

Employer: City of Palm Springs

Date of Injury or Illness: \_\_\_\_\_ Time: \_\_\_\_\_ AM \_\_\_\_\_ PM

Department: \_\_\_\_\_

Division/Location: \_\_\_\_\_

Name of Injured Employee: \_\_\_\_\_

Occupation / Job Title: \_\_\_\_\_

Was medical treatment offered?  Yes  No

What type of medical treatment was given?

Was treatment refused?  Yes  No

First Aid  Paramedics  Emergency Room  Hospitalization

Was employee given a claim form?  Yes  No

Clinic  Authorized  Other: \_\_\_\_\_

Pre-designated Physician's Name, if any: (attach form): \_\_\_\_\_

Was employee required to leave work due to this injury or illness?  Yes  No Date Last Worked if off work: \_\_\_\_\_

Has employee returned to work?  Yes, Date Returned: \_\_\_\_\_  No, Still Off Work

Name of person injury or illness was reported to: \_\_\_\_\_

Was incident reported immediately?  Yes  No If not, why: \_\_\_\_\_

Location where accident or exposure occurred: \_\_\_\_\_

List property damage, if any: \_\_\_\_\_

What was employee doing at the time of injury or exposure? \_\_\_\_\_

Person, object or substance that directly injured employee: \_\_\_\_\_

### WITNESS INFORMATION

Was the injury or exposure witnessed?  Yes  No, if yes complete this section

Witness 1 Name: \_\_\_\_\_

Witness 2 Name: \_\_\_\_\_

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

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

City/State/Zip: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Telephone: \_\_\_\_\_

Body Part Injured (check all that apply, indicate left and/or right):

Head  Neck  Face  Eye  Arm  Wrist  Finger  Ankle  Knee  Foot  Toe  Leg  Back

Other \_\_\_\_\_ Describe body part (left, right, pinkie, etc.) \_\_\_\_\_

Nature of Injury/Illness:

Scrape  Bruise  Burn  Fracture  Cut  Puncture  Sprain/Strain  Poisoning  Skin Problem

Heat  Cold  Foreign Body  Loss of Consciousness  Chemical Related Problem

Respiratory Problem  Other \_\_\_\_\_

Check any of the following unsafe actions which apply:

Haste/Unsafe Speed

Improper Procedure

Unsafe Lifting

Assault

Not Authorized

Unsafe Equipment Usage

Unsafe Position

Horseplay

Disregard of Instructions

Defective Equipment/Tools

Running/Jumping

Inattention

Lack of Knowledge Skill/Training

Inattention

Poor Housekeeping

Act of Other

Failure to Use Proper Equipment

Inadequate Protective Gear

Physical Handicap

Carelessness

Alcohol/Drugs

Other \_\_\_\_\_

I know the injury occurred on duty.  I have no specific knowledge the injury occurred on duty.

What steps have been taken or recommended to prevent recurrence? \_\_\_\_\_

Comments: \_\_\_\_\_

Attach additional documentation as necessary

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_