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 Office of Human Resources, Training & Development **within 24 hours of injury.**

Employee's Name: _____ Position: _____

Social Security #: _____ Phone: H) _____

Address: _____

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 back, etc.):

Describe how injury occurred:

Names of witnesses: _____

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

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

Doctor's name: _____ Phone: _____

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

Your Name: _____ 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: _____

Sign

_____ 8/4/2022 | 12:02 PM PDT

Supervisor's Signature Date

***Unless the employee has pre-designated their personal physician, the initial injury evaluation should be directed to Kaiser Industrial Medicine or WorkHealth 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