Supervisor's Report of Workplace Accident

This form must be filled out by the individual who supervised the injured worker at the time of the accident and submitted along with the completed FORM OWC-3 to the Division's designated Safety Coordinator **immediately** after a workplace injury. The Division shall then forward this form to the Office of Risk Management **immediately** following the report of the injury. Please attach additional sheets if necessary. Please write clearly. Failure to complete this entire form in a timely manner is a violation of City policy and may result in discipline.

SUPERVISOR'S INFORMATION

Supervisor's Name:	Supervisor's Job Title:
Supervisor's Work Phone Number:	Supervisor's Work Location:
Department:	Division:

INJURED WORKER'S INJURY INFORMATION

Injured Worker's Name:		Injured Worker's Job Title:
Department:	Division:	Work Location:
Date of Injury:	Time of Injury:	Date & Time Reported:

Explain how employee was injured:

Was employee on duty when injury occurred? : Yes ___ No ___ If not on duty please explain:

Did the injury occur on City property? : Yes ___ No ____

List job duties employee was performing at time of injury:

What equipment or tools were being used? :

Nature and extent of injuries. Check boxes and lines below to indicate which body parts were affected:

☐ Abdomen / Stomach	☐ Face	☐ Leg (Upper – above knee) (__ Right / __ Left)
☐ Ankle (__ Right / __ Left)	☐ Finger(s) - Which hand? ☐ Right ☐ Left	☐ Mouth
☐ Arm (Lower – below elbow) (__ Right / __ Left)	__ 1st (Thumb)/ __ 2nd (Index) /__ 3rd / __ 4th / __ 5th	☐ Neck
☐ Arm (Upper – above elbow) (__ Right / __ Left)	☐ Foot (__Right / __ Left)	☐ Nose
☐ Back: __ Upper / __ Mid / __ Low	☐ Hand (__ Right / __ Left)	☐ Ribs
☐ Buttocks	☐ Head	☐ Scalp / Skin (Specify location below)
☐ Chest	☐ Hip / Pelvis (__ Right / __ Left)	☐ Shoulder (__ Right / __ Left)
☐ Ear (__ Right / __ Left)	☐ Jaw	☐ Toe(s) - Which Foot? ☐ Right ☐ Left
☐ Elbow (__ Right / __ Left)	☐ Knee (__ Right / __ Left)	__ 1st (Big Toe) __ 2nd / __ 3rd / __ 4th / __ 5th
☐ Eye (__ Right / __ Left)	☐ Leg (Lower – below knee) (__ Right / __ Left)	☐ Wrist (__ Right / __ Left)

Did you witness the injury: Yes ___ No ____
It is your responsibility to investigate what happened whether or not you were a witness to the accident.

Name, job title and phone number of all witnesses to the injury (attach additional sheets if necessary):
1.
2.

Was the injury a result of a motor vehicle accident: Yes ___ No ___
If yes, was a police report completed? : Yes ___ No ___ Date of Report: ______________________

Could the injury have been avoided? : Yes ___ No ___ How? :

Did injured employee return to work? : Yes ___ No ___ If yes, when? :

Did employee seek immediate medical treatment? : Yes ___ No ___
If no, was medical treatment offered and declined by injured worker? : Yes ___ No ___

Additional comments regarding this injury:

What corrective action will be taken to prevent reoccurrence of similar injuries:

Supervisor's Signature: ________________________________ Date: ________________________

Appointing Authority's Signature: ___________________________ Date: ________________________

Division Organization number: _________________ Injured employee's alpha number: _____________