

ICRMT
WC Supervisor Report
(to be completed by supervisor of injured employee)

Injured Employee Name: _____ SSN: _____

Employee Home Phone: _____ Employee's approximate weekly wage: _____

Supervisor's Name and Title: _____

Date/Time of Accident: _____ Date/Time Employee Reported: _____

Medical Expenses so far (if known): _____

Did/will employee lose time from work as a result of this accident? Yes No

If yes, please list dates/timeframes missed due to this accident: _____

If lost time: Did or will the lost time exceed 3 consecutive scheduled work shifts? Yes No

Is there a possibility of accommodating a modified duty position during any recovery period? Yes No

If no, reason why: _____

Was medical treatment performed outside of the employer's facility? Yes No

If yes, was this medical provider (select all that apply): Occupational Health Provider
 Chosen by employee
 Other

Did the employee see more than one physician for this accident? Yes No

What object or substance, if any, directly harmed the employee? _____

Did the accident occur on the employer's premises? Yes No

Please review the employee's report of injury. Do you agree with the employee's details of this accident? Yes No

If no, please explain thoroughly (use 2nd sheet if necessary): _____

What did the employee tell you regarding what happened for the incident to occur? _____

What was the sequence of events that led up to the accident? What material, equipment and tools were involved? _____

What were the environmental conditions at the accident site? _____

What was done immediately after the accident? _____

Specify body parts injured in this accident: _____

Injury Type (i.e. sprain, fracture, etc.): _____

Accident Location: _____

Loss Causation: _____

What conditions or actions contributed to the accident? _____

What system design and implementation problems contributed to the accident occurrence? _____

What actions will be taken to reduce unsafe conditions and actions? _____

What actions will be taken to strengthen system design and implementation? _____

Would you like Method Management to contact you for further risk management assistance? Yes No

Do you believe an outside/3rd party is responsible for this accident occurring? Yes No

If yes, please indicate the responsible party's name, address and phone number if known: _____

I agree the above is true and accurate

Supervisor Name: _____ Supervisor Phone: _____

Supervisor's Signature: _____ Date: _____