SUPERVISOR'S INVESTIGATION REPORT

PLEASE FAX OR MAIL (847-433-2940) ACCIDENT REPORT FORM TO HR WITHIN 48 Hours

This report shall be completed (typewritten) by the supervisor of the injured employee, **no later than 24 hours after the end of the injured person's work shift.** The report shall then be reviewed and approved by the department head, and then forwarded to the claims coordinator (HR) **within 48 hours**, along with the employee's statement of injury and photographs of the site where the injury occurred.

The unsafe acts of persons and the unsafe conditions that cause accidents can be corrected only when they are known specifically. It is the supervisor's responsibility to find them, name them, to state the remedy for them in this report, and to ensure that corrective steps are taken immediately to remedy the unsafe conditions or acts.

SUPERVISOR'S NAME:	DATE & TIME OF ACCIDENT Date: Time: AM ☐ PM ☐

NAME OF INJURED EMPLOYEE:	PHONE#:	INJURED EMPLOYEE'S DEPT:	INJURED EMPLOYEE'S POSITION:

INJURED PERSON STATUS
FULL TIME ☐ PART TIME ☐ SEASONAL ☐ CONTRACT ☐ VOLUNTEER ☐ MISC. ☐

TIME IN JOB
IN TRAINING ☐ UNDER 6 MONTHS ☐ 6 MONTHS TO 1 YEAR ☐ 1 TO 5 YEARS ☐ OVER 5 YEARS ☐

DATE OF HIRE:	AVERAGE NUMBER OF HOURS WORKED PER WEEK :	HOURLY RATE:

DATE INJURED PERSON REPORTED ACCIDENT: TO WHOM REPORTED:

LOCATION OF ACCIDENT (The name or number of building, store, dept., floor, etc.)

DESCRIBE THE INJURY (Be specific, "right wrist", "lower back", etc.)

DESCRIBE THE ACCIDENT (State what the injured was doing and the circumstances leading to the accident)

WAS EMPLOYEE REQUESTED TO GO TO A MEDICAL MANAGEMENT NETWORK FACILITY FOR TREATMENT? YES ☐ NO ☐	IF RESTRICTED, IS LIGHT DUTY AVAILABLE? YES ☐ NO ☐
IS EMPLOYEE STILL TREATING WITH A MEDICAL MANAGEMENT NETWORK FACILITY? YES ☐ NO ☐	NAME & ADDRESS OF TREATING DOCTOR:

DID/WILL INJURED PERSON MISS **MORE THAN 3 WORKDAYS** DUE TO THIS ACCIDENT?
YES ☐ NO ☐ UNKNOWN ☐

# OF WORK DAYS INJURED PERSON MISSED:	DATE STARTED LOSING TIME:

ANY WITNESSES TO THIS INJURY/ACCIDENT?
YES ☐ NO ☐ (IF YES, PROVIDE WITNESS INFORMATION BELOW)

WITNESS NAME	POSITION:	PH#
WITNESS NAME	POSITION:	PH #

HOW COULD THE INJURY/ILLNESS HAVE BEEN PREVENTED?

REMEDY (As a supervisor, what action have you taken or do you propose taking to prevent a repeat accident?)

_____ SUPERVISOR' S SIGNATURE	DEPARTMENT HEAD'S NAME	DATE REPORT PREPARED
MY SIGNATURE INDICATES THAT I HAVE REVIEWED AND APPROVED THIS REPORT AS COMPLETE AS SUBMITTED: _____ DEPARTMENT HEAD'S SIGNATURE		DATE REPORT APPROVED
MY SIGNATURE INDICATES THAT I HAVE REVIEWED AND APPROVED THIS REPORT AS COMPLETE AS SUBMITTED: _____ CLAIMS COORDINATOR'S SIGNATURE		DATE REPORT RECEIVED

USE REVERSE SIDE FOR ADDITIONAL SPACE NEEDED

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