Supervisor's Report

The injured employee's supervisor must complete both pages of this form with as much detail as possible.

UNIVERSITY OF DENVER

Your Name _____ Department _____
Work phone number _____ Best contact phone number _____

Injured Party Information:
Full name _____ DU ID # 87_____
University Status: ☐Staff ☐Faculty ☐Student Employee ☐DU student completing an unpaid internship/practicum

REQUIRED: Employee's regular work schedule – please enter times or number of hours on each day:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	**Total** Weekly Hours

If an employee works an overnight shift, please document that shift's hours on the day of the week the shift starts.

Incident Information:
Date of notification _____ Date of incident _____ Time of Incident ____:____ ☐AM ☐PM
Did the employee finish their shift on the date of the incident? ☐Yes ☐No
Did the employee receive any medical treatment? ☐First Aid ☐Workers' Comp Clinic ☐Hospital ☐Other:_____

Did the employee ignore any instructions that would have prevented the injury or made the injury less severe?

What was the exact location of the incident? (Ex. Southeast staircase of Sturm Hall, 3rd floor, etc.)	Provide a detailed description of the incident.
What specific body part(s) was injured? (Ex. left elbow, lower back on right side, etc.)	In your opinion, what caused the incident/injury?
Was the injury the result of the employee not following safety rules, Standard Operating Procedures (SOPs), or Job Hazard Analysis (JHA)? If yes, please describe.	Was the employee instructed to use personal protective equipment (PPE)? Was the employee wearing the appropriate PPE? If no, please describe.
Describe any contributing factors that may have been present (wet floors, snowy weather, controlled indoor environment, etc.).	What corrective measures will you take or implement to avoid another incident of this type? Re-training? Be specific.

What was the nature of the injury?

☐Strain/Sprain ☐Lifting/handling materials ☐Pushing/pulling ☐Reaching/twisting ☐Crawling/bending	☐Repetitive Motion ☐Typing/mousing ☐Other repetitive motion
☐Puncture/Cut ☐Tools/equipment ☐Surface/object ☐Bite-insect/animal	☐Slip/Fall ☐Wet surface ☐Stairs ☐Ice/weather related ☐Over objects ☐Uneven surfaces ☐From heights
☐Struck ☐Falling/moving object ☐Tools/equipment ☐Stationary object ☐Person	☐Exposure ☐Temperature extremes ☐Chemical ☐Foreign object ☐Noise
☐Other ☐Personal health condition ☐Allergic reaction ☐Other: _____	☐Auto ☐DU driver caused accident ☐Other driver caused accident ☐Police Report #:_____

Do you have any concerns about this claim? Please describe. Attach additional pages if needed.

Additional Information

Did employee receive the Workers' Comp Medical Providers list? ☐Yes ☐No Date given to employee: ___/___/_____

Were pictures taken of the accident scene? ☐Yes ☐No If yes, please email them with this report.

Do you have witness statements? ☐Yes ☐No If yes, please submit a copy with this report.

Was a Campus Safety Report completed? ☐Yes ☐No If yes, what is the report number? _____

Additional Comments

Supervisor Signature: _____ Date: _____/_____/_____

Email this completed Supervisor's Report with (1) the signed Workers' Compensation Medical Providers list and (2) the Employee Report of Injury form to Enterprise Risk Management at risk@du.edu. Please scan these forms to yourself and then forward the email with the scans to risk@du.edu so that you know they will be received by ERM.