

### Supervisor's Report

**\*\*The injured employee's SUPERVISOR should complete both pages of this form. Please answer every question with as much detail as possible. If you need help or have questions please contact the Enterprise Risk Management at 1-3810. Information can be typed into form but cannot be saved.**

Supervisor completing this report \_\_\_\_\_ Department \_\_\_\_\_

Telephone number \_\_\_\_\_ Contact number \_\_\_\_\_

#### Injured Party Information

Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date of Hire \_\_\_\_\_

University Status: Student  Faculty  Staff

#### Accident Information

Date of notification \_\_\_\_\_ Date of incident \_\_\_\_\_ Time of Incident \_\_\_\_\_  AM  PM

What medical treatment did the employee receive?

First Aid  WC Medical Clinic  Hospital  Other

#### Description of the Incident

What was the exact location of the accident? (Ex. South east stairs of Sturm Hall; 2000 E. Asbury St)	Give a detailed description on the accident.
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.)	In your opinion, what was the root cause of the accident?
What specifically was the employee doing at the time of the accident (Ex. lifting boxes, pushing carts, etc.?)	What body parts were injured (be specific, left elbow and wrist).
Was the employee instructed to use protective equipment? Were they wearing the appropriate PPE? (If no, please describe.)	What corrective measures will you take or implement to avoid another incident of this type?
Describe any contributing factors that may have been present (wet floors, snowy weather, controlled indoor environment, etc.)	Do you have any questions or concerns regarding this claim? (If yes, please describe.)
Could the entire staff benefit from re-training?	What re-training was completed with the injured employee?

**What was the nature of the injury?**

<input type="checkbox"/> Strain /sprain from <input type="checkbox"/> Lifting/handling materials <input type="checkbox"/> Pushing/pulling <input type="checkbox"/> Reaching/twisting <input type="checkbox"/> Crawling/bending	<input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Typing/mousing <input type="checkbox"/> Other repetitive motion
<input type="checkbox"/> Puncture/Cut by <input type="checkbox"/> Tools/equipment <input type="checkbox"/> Surface/object <input type="checkbox"/> Bite-insect/animal	<input type="checkbox"/> Struck by <input type="checkbox"/> Falling/moving object <input type="checkbox"/> Tools/equipment <input type="checkbox"/> Stationary object <input type="checkbox"/> Person
<input type="checkbox"/> Slip/Fall <input type="checkbox"/> Wet surface <input type="checkbox"/> Ice/weather related <input type="checkbox"/> Stairs <input type="checkbox"/> Uneven surfaces <input type="checkbox"/> Over objects <input type="checkbox"/> From heights	<input type="checkbox"/> Exposure <input type="checkbox"/> Temperature extremes <input type="checkbox"/> Chemical <input type="checkbox"/> Foreign object <input type="checkbox"/> Noise
<input type="checkbox"/> Other <input type="checkbox"/> Personal health condition <input type="checkbox"/> Allergic reaction <input type="checkbox"/> Other	<input type="checkbox"/> Auto <input type="checkbox"/> DU driver caused <input type="checkbox"/> Other driver caused

**Additional Information**

Date you provided the provider choice letter: \_\_\_\_\_

Were pictures taken of the accident scene? Yes  No

Do you have witness statements? Yes  No

Was a Campus Safety Report completed? Yes  No  If yes what is the report number? \_\_\_\_\_

**Additional comments**

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please **PRINT**, **SIGN**, and **RETURN** form to Enterprise Risk Management at:  
 303-871-4455 (fax) - or - risk@du.edu (email)