UNIVERSITY of DENVER
Enterprise Risk Management

Supervisor's Report

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

Supervisor's name _____ Department _____
Work phone number _____ Best contact phone number _____

Injured Party Information:

Last name _____ First name _____ M.I. _____
DU ID number _____
University Status: ☐Student Employee ☐Faculty ☐Staff

Incident Information:

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

What was the exact location of the incident? (Ex. Southeast stair case of Sturm Hall, 3rd floor, etc.)	**Provide a detailed description of the incident.**
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 caused the incident/injury?**
What specifically was the employee doing at the time of the incident? (Ex. lifting boxes, pushing carts, etc.)	**What specific body part(s) was injured? (Ex. left elbow, lower back on right side, etc.)**
Was the employee instructed to use personal protective equipment (PPE)? Was the employee 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. Please attach additional pages if needed.**
Could staff benefit from re-training?	**What re-training will you have the involved employee(s) complete?**

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	☐Struck ☐Falling/moving object ☐Tools/equipment ☐Stationary object ☐Person
☐Slip/Fall ☐Wet surface ☐Ice/weather related ☐Stairs ☐Uneven surfaces ☐Over objects ☐From heights	☐Exposure ☐Temperature extremes ☐Chemical ☐Foreign object ☐Noise
☐Other ☐Personal health condition ☐Allergic reaction ☐Other: _____	☐Auto ☐DU driver caused ☐Other driver caused

Additional Information

Did the employee receive the "Workers' Compensation Medical Provider" form? ☐Yes ☐No

Date medical provider form was given to employee: _____/_____/_____

Were pictures taken of the accident scene? ☐Yes ☐No If yes, please submit 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: _____/_____/_____

Please email this completed Supervisor's Report with the Employee First Report of Injury form and the signed Workers' Compensation Medical Providers form with "DU Confidential" in the subject line to Enterprise Risk Management at risk@du.edu.