



LABBB Collaborative

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

EMPLOYEE NAME: _____ S.S.N: _____

EMPLOYEE ADDRESS: _____

TELEPHONE NU:(H) _____ (C) _____ (W) _____

MARITAL STATUS: _____ DATE OF HIRE: _____

DEPARTMENT: _____ OCCUPATION: _____

DATE OF BIRTH: _____ SEX (M or F): _____ AVERAGE WEEKLY WAGE: _____

NUMBER OF DEPENDENTS: _____ DATE OF INJURY: _____

DESCRIPTION OF INJURY: _____

LOCATION ACCIDENT OCCURRED: _____

WITNESS: _____ WITNESS ADDRESS: _____

TELEPHONE NU: _____

TO WHOM WAS INJURY REPORTED TO/THEIR POSITION: _____

DID EMPLOYEE LOSE TIME FROM WORK? (Y or N) _____

WAS MEDICAL TREATMENT SOUGHT? (Y or N) _____ Tax ID Number: _____

MEDICAL FACILITY: _____

DATE INJURY WAS REPORTED: _____

INJURY: _____ BODY PART: _____

RETURN TO WORK DATE: _____

*******Supervisor's Complete Below*******

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED? WHY?

CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY: _____

REMARKS: _____

Investigated By: _____ Date: _____

Reviewed By: _____ Date: _____

School Nurse

Supervisor