

Supervisor's Incident Report

1 · CARE

Emergency: 911. Otherwise send to ICA now.

2 · PROVIDER LIST

Hand over the designated provider list before they leave. send to your insurer (WC1) within 10 days.

3 · THIS FORM

A. INJURED EMPLOYEE

FULL NAME

DATE OF BIRTH

PHONE

JOB TITLE / DEPARTMENT

HIRE DATE

SHIFT / HOURS

PREFERRED LANGUAGE ☐ English ☐ Español ☐ Other: EMPLOYMENT ☐ Full-time ☐ Part-time ☐ Temp / staffing

B. EMPLOYER

COMPANY

WORKERS' COMP INSURER

POLICY / CLAIM NO. (IF KNOWN)

SUPERVISOR COMPLETING THIS FORM

SUPERVISOR PHONE

CONTACT FOR ICA'S SAME-DAY CALL

C. WHEN AND WHERE

DATE OF INJURY

TIME OF INJURY

DATE REPORTED TO YOU

TIME REPORTED

EXACT LOCATION (BUILDING, LINE, BAY, OR JOB-SITE ADDRESS)

HOURS INTO SHIFT

REPORTED BY ☐ Employee ☐ Co-worker ☐ Supervisor witnessed itON EMPLOYER PREMISES? ☐ Yes ☐ No — where:

D. WHAT HAPPENED

TASK BEING PERFORMED AND HOW LONG THEY HAD BEEN DOING IT

DESCRIPTION IN THE EMPLOYEE'S OWN WORDS (QUOTE THEM; CONTINUE IN SECTION H IF NEEDED)

EQUIPMENT, TOOLS, MATERIALS, OR VEHICLE INVOLVED

PPE REQUIRED FOR THE TASK / PPE WORN

TYPE ☐ Lift / strain ☐ Slip, trip, fall ☐ Struck by / against ☐ Caught in / between ☐ Cut / puncture ☐ Burn / chemical ☐ Vehicle ☐ Repetitive ☐ Other

E. INJURY AND CARE

BODY PART(S) AND SIDE — BE SPECIFIC (E.G. LOW BACK, RIGHT SIDE; LEFT INDEX FINGER)

NATURE ☐ Sprain / strain ☐ Cut / laceration ☐ Bruise ☐ Fracture
☐ Burn ☐ Eye ☐ Other

CARE PROVIDED

☐ First aid on site by
☐ Sent to ICA — clinic
☐ ICA transport requested at
☐ ER / 911 — facility
☐ Declined care (employee initials)

E. INJURY AND CARE, CONTINUED

PROVIDER LIST ☐ Written list given at ☐ Employee signed acknowledgment ☐ Status today ☐ Returned to work ☐ Left for care ☐ Sent home

F. WITNESSES

NAME	PHONE	WHAT THEY SAW (ONE LINE, THEIR WORDS)

☐ No witnesses ☐ Written witness statements attached

G. SCENE AND FOLLOW-UP

☐ Photos taken of area, equipment, hazard — count	☐ Insurer notified (WC1) — date / conf. no.
☐ Equipment / tool tagged out pending inspection	☐ OSHA 300 log reviewed for recordability
☐ Hazard corrected — describe below	☐ OSHA notified (fatality 8 h / in-patient, amputation, eye 24 h)

SUPERVISOR'S OBSERVATIONS AND IMMEDIATE CORRECTIVE ACTION (FACTS ONLY)

H. CONTINUATION (EMPLOYEE DESCRIPTION, ADDITIONAL DETAIL)

I. SIGNATURES

This report records the facts as reported and observed on the date above. Workers' compensation is no-fault: signing does not admit fault by the employee or the employer. The employee's signature confirms the description in Section D reflects what they told the supervisor.

Employee signature · date

Supervisor signature · title · date

Reviewed by (HR / safety) · date

Interpreter (if used) · name · date

Distribution

Original: employer claim file (keep 6 years after closure). Copies: insurer with the WC1 · employee on request · attach to OSHA 301 if recordable.

Send a copy to ICA

Fax or email it to the treating clinic. It goes in the chart and helps us write precise restrictions.

Questions

Call the clinic the same day. We answer reporting questions whether or not the worker has been seen yet.