



SUPERVISOR'S INVESTIGATION REPORT

Employee Name: _____
 Date of Injury: _____

Was an investigation completed concerning the circumstances of this injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Were there any witnesses to this injury? If yes, witness statement should be attached.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the injury a result of horseplay? Under the influence of drugs, or purposely self-inflicted? If yes, please specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
_____ _____ _____		
Has there been any recent disciplinary action taken against this employee? If yes, please describe (and attach any written documentation):	<input type="checkbox"/> Yes <input type="checkbox"/> No	
_____ _____		
Has the employee missed any work previously due to similar industrial or non-industrial conditions? If so, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
What preventive action measures do you recommend?		
_____ _____ _____		
Has the employee submitted medical documentation for the injury? If so, please attach.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If know, please provide us with the name, address and telephone number of the attending physician:		
_____ _____ _____ _____		
Has the employee returned to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Last day worked _____ Returned to work _____		
If not, what is the current estimated ate of return? _____		
With the information you have, would you recommend the claim be accepted? If no, why?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
_____ _____		
_____ Supervisor's Signature	_____ Title	_____ Date

PLEASE ATTACH COMPLETED INCIDENT REPORTS, WITNESS STATEMENTS AND ANY ACCUMULATED MEDICAL BILLS AND INFORMATION. ADDITIONAL COMMENTS MAY BE NOTED ON THE REVERSE SIDE.