



SUPERVISOR'S REPORT OF INJURY INSTRUCTIONS

Injury—No Treatment Required

1. **SUPERVISOR** downloads and completes Supervisor Report of Injury Form (**do not** have employee fill out).
2. Have employee sign.
3. Supervisor to send copy to Risk indicating no treatment sought at this time. Instruct employee to return for copy of Report of Injury form if treatment is required.
4. Go to line 4 of the 'Treatment Required' instructions once employee requests copy of Report of Injury form.

Injury—Treatment Required

1. **SUPERVISOR** downloads and completes Supervisor Report of Injury Form (**do not** have employee fill out).
2. Have employee sign.
3. Give copy of Report of Injury form to employee. Keep a copy of form and forward (e-mail or FAX) to Risk without delay.
4. Provide Prescription form to employee.
5. Direct employee to appropriate facility (**ER is LAST RESORT**).
6. Inform employee of light duty.
7. Require work status slip after all physician visits—turn into Risk.

SUPERVISOR'S REPORT OF INDUSTRIAL INJURY		MODIFIED DUTY IS AVAILABLE		Risk Management Use Only	
COMPLETE AND E-MAIL THIS REPORT TO RISK MANAGEMENT WITHIN 24 HOURS OF ACCIDENT		Billing Address: Arizona Counties Insurance Pool 1905 W. Washington St., Suite 200 Phoenix, AZ 85009		OSHA Case #: _____ Work Comp #: _____	
FATALITIES MUST BE REPORTED WITHIN 4 HOURS					
LAST NAME		FIRST NAME		MI	SOCIAL SECURITY NUMBER
					BIRTH DATE
STREET ADDRESS (NUMBER & STREET)		CITY	STATE	ZIP	HOME TELEPHONE
MAILING ADDRESS (NUMBER & STREET)		CITY	STATE	ZIP	
SEX		MARITAL STATUS			
MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>			
EMPLOYER'S NAME			DEPT		
ADDRESS (NUMBER & STREET)			CITY	STATE	ZIP
			WORK TELEPHONE		
Date of Injury	Time of Injury	Date Employer Notified of Injury		Date Employee Left Work	Date Returned to Work
Employee's Occupation (Job Title) When Injured					
Address or Location of Accident		City	County	State	Zip
On Employer Premises?		Nature of Injury (Scratch, Cut, Bruise, etc.)		Fatal?	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
Part of Body Injured					
Will Treatment Be Sought?		If Yes, Where?			
What was Employee Doing When Accident Occurred? (Loading Truck, Walking Down Stairs, etc.)			Where Did Accident Occur?		
Specify Machine, Tool, Substance of Object Most Closely Connected With Accident			Were Others Injured in This Accident?		
How Did Accident Happen? (State All Details; Use Additional Page if Needed)					
If Validity of Claim is Doubted, State Reason:					
Was Personal Protective Equipment Being Worn? Yes <input type="checkbox"/> No <input type="checkbox"/>					
If Yes, What Type? (Check One or More Items Below):					
<input type="checkbox"/> Protective Clothing		<input type="checkbox"/> Seat Belts		Other (explain)	
<input type="checkbox"/> Foot Protection		<input type="checkbox"/> Hearing Protection			
<input type="checkbox"/> Eye Protection		<input type="checkbox"/> Respirator			
<input type="checkbox"/> Head Protection		<input type="checkbox"/> Back Support Belt			
If Another Person Not in County Employ Caused Accident, Give Name and Address:					
Employee's Date of Hire	Employee's Work Hours	Employee's Scheduled Work Days		Was Employee on Overtime When Injury Occurred?	
Witness Information:		Name, Address, City, State, Zip		Area Code, Telephone Number of Each Witness	
Additional Comments on Separate Sheet and Attach					
Employment Category					
<input type="checkbox"/> Regular, Full-Time <input type="checkbox"/> Regular, Part-Time <input type="checkbox"/> Temp <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer					
Supervisor Print Name	Sign Name	Phone No.	Date	Title	
Employee Print Name	Sign Name	Office Direct Line #	Date	Title	