



SUPERVISOR'S REPORT OF INJURY

INJURED WORKER NAME: _____

EMPLOYEE ID# _____

DEPARTMENT: _____

DATE OF INJURY: _____ TIME OF INJURY: _____ AM/PM

DESCRIPTION:

MEDICAL TREATMENT: ___ NONE ___ HOSPITAL ___ DOCTOR
___ FIRST AID

WHAT WAS THE EMPLOYEE DOING WHEN THE INCIDENT
OCCURRED? _____

FOR PHYSICAL FACILITIES EMPLOYEES

SANDRA SMITH, PHONE NUMBER (330) 972-7313.

FOR ALL OTHER EMPLOYEES

LUCILLE GENOVESE, PHONE NUMBER (330) 972-7886.

ANY FURTHER INFORMATION OR DOCUMENTATION SHOULD BE
FORWARDED TO THE SAME.