ICRMT
WC Supervisor Report
(to be completed by supervisor of injured employee)

Injured Employee Name: _____ SSN: _____

Employee Home Phone: _____ Employee's approximate weekly wage: _____

Supervisor's Name and Title: _____

Date/Time of Accident: _____ Date/Time Employee Reported: _____

Medical Expenses so far (if known): _____

Did/will employee lose time from work as a result of this accident? ☐ Yes ☐ No

If yes, please list dates/timeframes missed due to this accident: _____
If lost time: Did or will the lost time exceed 3 consecutive scheduled work shifts? ☐ Yes ☐ No
Is there a possibility of accommodating a modified duty position during any recovery period? ☐ Yes ☐ No

If no, reason why: _____

Was medical treatment performed outside of the employer's facility? ☐ Yes ☐ No

If yes, was this medical provider (select all that apply): ☐ Occupational Health Provider
☐ Chosen by employee
☐ Other

Did the employee see more than one physician for this accident? ☐ Yes ☐ No

What object or substance, if any, directly harmed the employee? _____

_____

Did the accident occur on the employer's premises? ☐ Yes ☐ No

Please review the employee's report of injury. Do you agree with the employee's details of this accident? ☐ Yes ☐ No

If no, please explain thoroughly (use 2nd sheet if necessary): _____

_____

_____

What did the employee tell you regarding what happened for the incident to occur? _____

_____

_____

What was the sequence of events that led up to the accident? What material, equipment and tools were involved? _____

_____

What were the environmental conditions at the accident site? _____

What was done immediately after the accident? _____

Specify body parts injured in this accident: _____

Injury Type (i.e. sprain, fracture, etc.): _____

Accident Location: _____

Loss Causation: _____

What conditions or actions contributed to the accident? _____

What system design and implementation problems contributed to the accident occurrence? _____

What actions will be taken to reduce unsafe conditions and actions? _____

What actions will be taken to strengthen system design and implementation? _____

Would you like Method Management to contact you for further risk management assistance? ☐ Yes ☐ No

Do you believe an outside/3rd party is responsible for this accident occurring? ☐ Yes ☐ No

If yes, please indicate the responsible party's name, address and phone number if known: _____

I agree the above is true and accurate

Supervisor Name: _____ Supervisor Phone: _____

Supervisor's Signature: _____ Date: _____