

SUPERVISOR'S STATEMENT FORM

Employee Name: _____

Date and time of incident: _____

Where did it happen _____
street address or department/location at the time of injury

List witnesses and phone numbers, including anyone that may have knowledge of the incident, if known.

Name: _____ Phone # _____

Name: _____ Phone # _____

Did the employee lose any work time due to the alleged injury? Yes No

Did the employee go to the doctor? Yes No

Did the employee go to the doctor on own? Yes No

Treating Doctor's Name: _____ Phone # _____

Hospital Name: _____ Phone # _____

Has the employee returned to work? Yes No (as of date of this report)

How long is the employee expected to be off work? _____

What happened? (describe fully what took place or what caused you to make this investigation.)

Date and time employee reported incident to manager/supervisor _____

Investigated by: _____ Title _____ Date _____ Phone # _____

Supervisor's signature

Date