FORM #RM01

AdminSure, Inc.

Supervisor's Report of Injury or Illness

(Complete for All Employee Reported Injuries)

Employer: _____ Nature of Business: _____

Department: _____ Division/Location: _____

Name of Injured Employee: _____

Occupation: _____

Date of Injury or Illness: _____ Time: _____AM _____PM

Was medical treatment offered? ☐ Yes ☐ No Was treatment refused? ☐ Yes* ☐ No

Was employee given a claim form? ☐ Yes ☐ No Employee's Signature: _____

Pre-designated Physician's Name: (attach form)_____

What type of medical treatment was given?

☐ First Aid * ☐ Paramedics ☐ Emergency Room

☐ Hospitalization ☐ Clinic ☐ Authorized

Was employee required to leave work due to this injury or illness? ☐ Yes ☐ No Date Last Worked: _____

Has employee returned to work? ☐ Yes, Date Returned: _____ ☐ No, Still Off Work

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Name of person injury or illness was reported to: _____

Timeliness of Reporting: If the accident was not reported immediately, why not? _____

_____

Location where accident or exposure occurred: _____

_____

What was employee doing at the time of injury or exposure? _____

_____

Person, object or substance that directly injured employee: _____

_____

Was the injury or exposure witnessed? ☐ Yes ☐ No

WITNESS INFORMATION

Name: _____ Name: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Telephone: _____ Telephone: _____

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List property damage, if any: _____

(continued on reverse)

Body Part Injured (check all that apply, indicate left and/or right):

_____ Head	_____ Upper Back	_____ Finger (which?)	_____ Ankle
_____ Face	_____ Lower Back	_____ Upper Leg	_____ Foot
_____ Eye	_____ Arm	_____ Lower Leg	_____ Toe (which?)
_____ Neck	_____ Wrist	_____ Knee	_____ Other _____

Nature of Injury/Illness:

_____ Scrape	_____ Burn	_____ Fracture	_____ Cold Related Problem
_____ Cut	_____ Sprain/Strain	_____ Skin Problem	_____ Loss of Consciousness
_____ Puncture	_____ Foreign Body	_____ Chemical Related Problem	_____ Respiratory Problem
_____ Bruise	_____ Poisoning	_____ Heat Related Problem	_____ Other _____

Check any of the following unsafe actions which apply:

_____ Haste/Unsafe Speed	_____ Improper Procedure	_____ Unsafe Lifting
_____ Not Authorized	_____ Unsafe Equipment Usage	_____ Unsafe Position
_____ Disregard of Instructions	_____ Defective Equipment/Tools	_____ Running/Jumping
_____ Lack of Knowledge Skill/Training	_____ Inattention	_____ Poor Housekeeping
_____ Failure to Use Proper Equipment	_____ Assault	_____ Act of Other
_____ Inadequate Protective Gear	_____ Horseplay	_____ Physical Handicap
_____ Carelessness	_____ Alcohol/Drugs	_____ Other _____

☐ I know the injury occurred on duty. ☐ I have no specific knowledge the injury occurred on duty.

What steps have been taken or recommended to prevent recurrence? _____

_____

Comments: _____

_____

Supervisor's Signature: _____

Date: _____

- Supervisor – If incident is designated as First Aid Only by the industrial clinic OR employee declines medical treatment, provide the employee with a blank Workers' Compensation claim form #DWC1. It is the employee's choice if they wish to complete the form and file a formal Workers' Compensation claim but a claim form must be offered.
- Employee – If the incident is designated as First Aid Only by the industrial clinic OR you do not wish to seek medical treatment at this time, it is not necessary to file a formal Workers' Compensation claim by completing the Workers' Compensation claim form #DWC1 provided to you by your supervisor. You may change your mind (about seeking medical treatment and filing a formal claim) up to one year after your date of injury.

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