SUPERVISOR'S REPORT OF INJURY / ILLNESS:

Employee's Name:_____

Supervisor's Name:

_____

Employee's Department:_____

Date Report filled out:_____ Date of Injury/Illness:_____

Time of Injury/Illness:_____

Date and Time reported to Supervisor:_____

Medical Treatment offered: ____Yes ____No

Medical Treatment accepted:____Yes_____No

Transported to Cox Medical Occupational Center:_____Yes ____No

How was the Employee transported for medical treatment and by whom:

_____

Informed Cox Medical Occupational Center that this could be a Worker's Comp:_____Yes ____No

Treatment Received:_____

_____

Prescriptions prescribed were:_____

_____

Who took prescriptions to pharmacy:

_____

How were prescriptions paid for:

_____

Follow-up Appointments:_____Yes ____No Date of Follow-up:_____

First Aid Applied:_____Yes_____No

Witnesses:_____Yes_____No Names of Witnesses:_____

Where Injury or Illness happened:

Nature of Injury or Illness:

Part(s) of Body affected:

For Supervisor: Please describe in your own words how injury / illness happened:

Date Supervisor's Report turned in to Human Resources:

Supervisor Signature: Date: