COUNTY OF TUOLUMNE
WORKER'SCOMPENSATION
SUPERVISOR'S INVESTIGATION REPORT

This report will be prepared by the IMMEDIATE SUPERVISOR of the Employee involved in any accident or incident resulting in injury or illness. Forward to the Human Resources/Risk Management Department within 24 hours of the accident or incident.
General Information: Please fill out this form completely, accurately, and legibly.

Employee_____ **Classification**_____ **Hourly Rate** _____

Department_____ **Division**_____ **Date of Hire** _____

Hours Worked: Per Day_____ **# Days**_____ **Total Weekly Hours:**_____ **Time Shift Started:**_____ **A.M. / P.M.**

Home Address_____ **City/State**_____ **Zip**_____

Phone #_____ **Email (Personal)**_____ **Date of Birth**_____

Social Security #_____ **Sex:** ❑ **M** ❑ **F**

INJURY OR ILLNESS

Date of Accident/Incident_____ **Time**_____ **AM**__ **PM**___ **Date Employee Reported Injury?**_____

Injury Reported to Whom?_____ **On County Premises** ❑ **Yes** ❑ **No**

Witness_____ **Phone**_____

Location (Address Injury Occurred)_____

Description of Accident/Incident (Please include tasks being performed, tools/objects involved that lead to and include incident):

_____

_____

Body Part(s) Involved: (Please Specify Right or Left) _____

Did Employee receive medical treatment?_____ **Name of Treating Physician** _____

Was Employee hospitalized?_____ **Name of Hospital** _____

Did Employee lose work time on any day after injury?_____ **Date Returned to Work*** _____

PREVENTION INVESTIGATION

Cause of Accident_____

Corrective action necessary to eliminate cause of accident _____

_____

Was safety equipment available?_____ **Was safety equipment properly used?** _____

Supervisor's recommendations

_____

_____

Supervisor's signature_____ **Classification**_____ **Date** _____

*** Department must notify Human Resources/Risk Management immediately when an employee returns to work after an injury or illness.**