

Citrus Community College District
Supervisor's Report Of Employee Injury

Supervisor: Submit this form within 24 hours to the Office of Human Resources. Only you or your designee shall complete this form on behalf of the injured employee.

Today's Date: _____ **Name of Injured:** _____

Date of Birth: _____ **Address & Telephone #:** _____

Job Title: _____ **Date Hired:** _____

Employee's Normal Work Schedule: _____

Date of Accident: _____ **Hour:** _____ am/pm

Location of Accident: (Please Be Specific): _____

Describe How the Accident Occurred (Facts Only. Exclude opinions or assumptions as to cause): _____

| Witness(es) If any: | Address | Phone: |
|----------------------------|----------------|---------------|
|----------------------------|----------------|---------------|

What is the observable nature of the Injury?
(Please describe): _____

On the day of the injury, did the employee, because of the injury:

Leave Work? _____, If yes, Date: _____ Time: _____ am/pm

Return to work? _____, If yes, Date: _____ Time: _____ am/pm

Corrective Action: What changes in the worksite or work procedures could be taken to prevent this accident from occurring again? _____

Supervisor's Signature: _____ **Date:** _____

Distribution:
Original to Human Resources
Copy to Safety Coordinator's Office