



Supervisor's Report of a Work Related Injury/Illness

Instructions: This form is to be completed by the supervisor when an employee is injured or becomes ill due to a work related incident. All questions are to be completed by the supervisor. Be explicit, factual and thorough. Please include all information related to the injury, including any cause that contributed to the claim of injury. If necessary, attach a separate sheet of paper. **The completed and signed form must be faxed to Berkley Administrators at 1-866-303-1398, within 24 hours after an injury/illness is reported.** For additional information, please call Berkley Administrators at 1-800-611-8535. Additional reporting guideline can be found your Risk Management Manual, Section 2.

Employee and Supervisor Information

Employee Name: _____

Employee's Lawson ID #: _____ Employee Social Security Number: _____

Department where employee works: _____ Job Title: _____

Home Address: _____ Home telephone number: _____
(Number and Street, City, State, and Zip)

Date and time of injury/illness: ____/____/____ ____ a.m. p.m.
(hour)

Date and time reported to supervisor: ____/____/____ ____ a.m. p.m.
(hour)

Time employee began work on the day of injury: ____ a.m. p.m.
(hour)

Employee usually works ____ hours per day, ____ days per week, ____ total hours per week

Employee's usual work schedule Monday to Friday ____ a.m. to ____ p.m. Other _____
(hour)

Supervisor's Name: _____ Phone Number: _____

Location of injury/illness

On Employer Premises?: Near or in what building? _____

If not on Employer Property: Address: _____

Injury/illness specifics

Describe injury/illness (BE SPECIFIC, i.e. sprain, strain, cut, body part): _____

Specific activity the employee was performing when event or exposure occurred:

How did injury/illness occur?: _____

What could have be done to prevent this injury?: _____

Names of witness(es) to injury/illness: _____



Supervisor's Report of a Work Related Injury/Illness Continued

Referral for treatment

Did the injury require medical treatment?

No – accident report only

Yes, Employee has been referred for treatment to (check one):

St. Mary's Occupational Health Center, 1320 West Main Street [203-709-3740]

Concentra Medical Center, 8 Commons Drive [203-759-1229]

Hospital or other, including name and location _____

Supervisor Signature: _____

Date: _____