TRISTAR
RISK MANAGEMENT

SUPERVISOR'S REPORT OF INJURY OR ILLNESS

Claim Number _____

This form must be completed thoroughly by employee's supervisor within 24 hours after an accident

PART I – GENERAL INFORMATION

Employee Name	Title		Social Security No.
Address	City/State	Zip	Home Phone
Agency	Location		Work Phone

Job Description and/or Assigned Duties of Employee (be specific):

Number of Years in current job title: _____

Previous job title: _____ Number of years previous title: _____

Activity at time of accident/incident: _____

Date of Accident/Incident	Hour: ◯ AM ◯ PM	Exact Location

Did you witness?	How was notice received?	Date Received	Time Received	From Whom Notice Received
■ Yes ☐ No	☐ Written ☐ Oral			

PART II – DETAILS OF ACCIDENT

Description of Accident/Incident:

Did a third party cause or contribute to the accident? ◯ Yes ◯ No

If yes, explain and provide name, address and phone number of negligent party (use reverse side if necessary):

Description of Injury – Part(s) of Body Injured:

Name(s) of Witness(es) (if none, so state):

PART III – CAUSE OF ACCIDENT

Describe any unsafe acts or conditions which contribute to the accident/incident:

PART IV – CORRECTIVE ACTION TAKEN

Was the condition above corrected (how)?	Reported to higher authority (Name & Title)?
Name and Title of Supervisor	Did the incident result in any disciplinary action? ◯ Yes ◯ No

_____ Signature of Supervisor/Phone Number

_____ Report Date

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