SUPERVISOR'S REPORT OF INJURY

(Maintain copy of report at your location.)

CHURCH/SCHOOL EMPLOYER NAME_____ SELF-INSURED # *2003119*

ADDRESS _____ CITY/STATE/ZIP _____

EMPLOYEE NAME _____ OCCUPATION _____

ADDRESS_____ CITY/STATE/ZIP _____

SOCIAL SECURITY # (last 4)_____ DATE OF INJURY _____

TIME OF INJURY_____AM / PM DATE REPORTED TO EMPLOYER _____

WITNESS (if any) _____

DESCRIPTION OF ACCIDENT (Describe in Detail) : _____

_____

_____

GIVE THE EXACT NATURE OF INJURY AND PART OF BODY AFFECTED (e.g. fracture of right hand, etc.):

_____

_____

_____

WAS EMPLOYEE TREATED AT WORK _____ YES _____ NO

DID EMPLOYEE RECEIVE OUTSIDE MEDICAL TREATMENT? _____ YES _____ NO

GIVE NAME OF HOSPITAL, CLINIC, AND/OR PHYSICIAN'S NAME _____

_____

LAST DATE WORKED _____ RETURN TO WORK DATE (if known) _____

SIGNING THIS REPORT DOES NOT CONSTITUTE CERTIFICATION OF AN INDUSTRIAL CLAIM.

_____ _____

EMPLOYEE'S SIGNATURE EMPLOYER'S SIGNATURE

_____ _____

DATE TITLE

_____

DATE