Tuolumne JPA
Serving Schools Since 1980
Alpine - Amador - Calaveras - Tuolumne

Supervisor's Report of Employee Injury

☐ **First Aid Claim**

☐ **Workers' Compensation Claim**

To Be Completed by Employer:

Employee Name ____________________

Occupation ____________________ Age ____________

Date of Injury ____________________ Time of Injury ____________

Date Reported ____________________ Time Reported ____________

Accident Location ____________________

Type of Injury ____________________

____

Medical Facility ____________________

Did Injured Leave Work? ____________ Date ____________ Time Reported ____________ *a.m.* *p.m.*

Did Injured Return to Work? ____________ Date ____________ Time Reported ____________ *a.m.* *p.m.*

1. Describe how the accident occurred ____________________

2. Names of witnesses ____________________

3. What steps have been taken to prevent similar accidents? ____________________

Supervisor's Signature ____________________ Date ____________