TRINITY COUNTY - SUPERVISOR'S REPORT OF EMPLOYEE INJURY

This form should be completed by supervisory/management staff to report all incidents, injuries, or illnesses sustained by agency staff. After completing this form, it should be attached to the "Incident /Hazard Report Form and sent to the Risk Management and Loss Prevention Department.

Name of injured:		
Date of Birth:	Job Title:	
Date of Injury:	Time: AM ○ PM ◉	
Date Reported:	Time: AM ○ PM ◉	
Accident Location:		
What was the Nature of Injury (*Describe in Detail*):		
Did employee go to the Doctor/Hospital? YES ○ NO ◉ If Yes, Please List below		
Name of Medical Facility:		
Address of Medical Facility:		
Did Injured Leave Work?	Date:	Time: ○ AM PM ◉
Did Injured Return to Work?	Date:	Time: ○ AM PM ◉
Describe How Accident Occurred? What was the Employee doing Prior to event?		
Names of Witnesses? *(if any)*:		
Action taken to prevent re-occurrence? Procedures reviewed? Follow-up training provided?		
Supervisor's Signature:		Date:
Department:		
DWC-1 Claim Form Provided? ◉ Yes	○ No	○ Employee Declined