



SUPERVISOR'S REPORT OF INJURY

Fax to Human Resources within 8 hours of injury @ (707) 527-4967

Name of injured: _____

Date of injury: _____ Date reported: _____

Time of injury: _____ am pm Time started work: _____ am pm

Job title: _____

Work location: Santa Rosa PSTC Windsor Petaluma Shone Farm Other _____

Hrs. worked/day: _____ Days/week: _____ Total weekly hrs: _____

Did employee lose at least one full day of work AFTER incident?

Yes No Date last worked: _____

If yes, has employee returned to work?

Yes, date returned _____ No

To your knowledge, did the employee see a physician for this injury/illness?

Yes No

If yes, give name and address of physician: _____

Place and location where accident or exposure occurred? _____

What was employee doing when injured? _____

Describe how the injury/illness occurred? _____

Object or substance that directly injured employee (e.g. teeth, nails, chair, etc.): _____

Describe the injury/illness (e.g. cut, strain, fracture, exposure): _____

Part of the body affected (i.e. back, wrist, leg, eye): _____

Name of witnesses: _____

What steps have been taken to prevent a similar accident?: _____

Supervisor's Signature: _____ Phone No: _____ Date: _____

Printed Supervisor's Name: _____