

Town of Manchester, Connecticut
Supervisor's Report of Accident/Injury/Illness

Please complete **BOTH** sides of this form in pen for any work related accident/injury/illness and send the original to Jan Devendorf in Human Resources.

INJURED EMPLOYEE'S INFORMATION

Department: _____ Employee Job Title: _____

Employee's Name: _____

Employee's Home Address: _____

City/State: _____ Zip: _____ Employee status: ft ____ pt ____

Employee's Telephone Number- Home: _____ Cell: _____

Gender: Male: ____ Female: ____ Date of Birth: _____ Date of Hire: _____

ACCIDENT/INJURY INFORMATION

Date of Occurrence: _____ Time of Occurrence: _____

Location where accident/injury/exposure occurred: _____

Description of Accident/Injury: _____

Check one:

- _____ Incident only, no medical attention
- _____ Medical attention, no lost time
- _____ Medical attention and lost work time

Did employee refuse medical treatment? yes _____ no _____

If treatment was given away from worksite, where? _____

Witness to accident: _____

Supervisor's Signature: _____ Telephone Number: _____

Reviewed by (Dept./Div Head): _____ Date: _____

My supervisor and I have reviewed and discussed the above accident/injury/illness.

Employee's signature Date

Called into CIRMA: _____ By: _____
Date Time Supervisor

1-800-OK-CIRMA (1-800-652-4762) Reference # _____

Supervisor's Incident Investigation

(To be completed by the employee's supervisor)

Who was injured?	Employer's Premises: Yes ___ No ___ Job site: Yes ___ No ___	Date of accident or illness
Location where accident/incident occurred		Time of accident _____ a.m. _____ p.m.
Employee Job title	Name of dept. normally assigned to	How long has employee worked at job where injury or illness occurred?
Part of body affected/injured.		Any prior physical conditions known? If so, what? Yes ___ No ___
How did injury/illness occur? List all objects and substances involved.		
What was employee doing when injury/illness occurred? Was machine or tool was being used?		

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

- | | | |
|---|--|---|
| <input type="checkbox"/> Improper lifting technique | <input type="checkbox"/> Improper maintenance | <input type="checkbox"/> Did not follow proper procedure |
| <input type="checkbox"/> Improper body mechanics | <input type="checkbox"/> Improper protective equipment | <input type="checkbox"/> Unsafe personal space/proximity to equip |
| <input type="checkbox"/> Horseplay | <input type="checkbox"/> Inoperative safety device | <input type="checkbox"/> Unsafe equipment |
| <input type="checkbox"/> Improper dress | <input type="checkbox"/> Lack of training or skill | <input type="checkbox"/> Unsafe position |
| <input type="checkbox"/> Failure to use PPE | <input type="checkbox"/> Failure to follow instruction | <input type="checkbox"/> Failure to use seatbelt |
| <input type="checkbox"/> Improper guarding | <input type="checkbox"/> Operating without authority | <input type="checkbox"/> Other _____ |

Supervisor's corrective action to ensure this type of injury/accident does not recur: (please state what was discussed with employee)

Did employee report the injury/illness within 24 hours of occurrence? Yes ___ No ___
 Was the accident/injury/illness/exposure discussed with the employee? Yes ___ No ___
 If applicable:
 Was employee cautioned for failure to use proper safety procedures?..... Yes ___ No ___
 Is there modified duty available?..... N/A ___ Yes ___ No ___

 Supervisor's Name (print) Supervisor's Signature Telephone Number Date