C I T Y O F C O R A L G A B L E S

EMPLOYEE JOB INJURY OR ILLNESS
SUPERVISOR REPORT

THE UNSAFE ACTS OF PERSONS AND THE UNSAFE CONDITIONS THAT CAUSES ACCIDENTS CAN BE CORRECTED ONLY WHEN THET ARE KNOWN SPECIFICALLY, IT IS YOUR RESPONSIBILITY TO FIND THEM AND NAME THEM AND TO STATE THE REMEDY FOR THEM IN THIS REPORT.

- **NAME OF EMPLOYEE:**_____**DEPT.DIVISION:** _____
- **DATE OF ACCIDENT:**_____**DATE & TIME SEEN PHYSICIAN/HOSPITAL:**_____
- **TO WHOM WAS IT FIRST REPORTED :**_____**DATE/TIME:**_____
- **HAVE YOU CONFIRMED THIS AS AN ON THE JOB INJURY** ❑ **YES** ❑ **NO**
- **NAME OF IMMEDIATE SUPERVISOR:**_____ **Ph: (W)**_____ **(Cell)**_____
- **WAS THIS FIRST REPORTED AS A MINOR INJURY ON THE MINOR INJURY LOG?** ❑ **Yes** ❑ **No Date:**_____ **Time:** _____ ❑ **am** ❑ **pm**
- **DID EMPLOYEE GO TO:** ❑ **CLINIC** ❑ **DOCTOR OR** ❑ **HOSPITAL? NAME OF CLINIC, DOCTOR OR HOSPITAL**_____

- **DESCRIBE THE INJURY:**

_____

_____

- **DESCRIBE THE ACCIDENT: (STATE WHAT THE INJURED WAS DOING AND THE CIRCUMSTANCES LEADING TO THE ACCIDENT)**

_____

_____

- **UNSAFE CONDITION: (DESCRIBE AS OILY FLOOR, POOR LIGHT, LACK OF GUARDS, NO EYE PROTECTION, ETC.)**

_____

_____

- **UNSAFE ACT / UNSAFE WORK CONDITION: (LACK OF PLANNING, REMOVED EYE PROTECTION, REMOVED GUARDS, ETC.)**

_____

_____

- **REMEDY: (AS A SUPERVISOR, WHAT ACTION HAVE YOU TAKEN OR DO YOU PROPOSE TO TAKE TO PREVENT A REPEAT ACCIDENT?)**

_____

_____

SUPERVISOR'S SIGNATURE / DATE	**DEPARTMENT HEAD'S SIGNATURE / DATE**	**EMPLOYEE'S SIGNATURE / DATE**
_____ _____	_____ _____	_____ _____

WITNESS (S) TO ACCIDENT: _____

_____

_____

REMARKS: _____

_____

_____

Submit to: ORIGINAL • RISK MANAGEMENT (Phone: 305-460-5527/Fax: 305-460-5518); 2801 SALZEDO STREET, CORAL GABLES, FL. 33134
Copy • EMPLOYEE FILE