CITY OF EVANSTON SUPERVISOR REPORT
EMPLOYEE INJURED ON DUTY

It is the responsibility of the employee's supervisor to immediately investigate the injury and forward a completed report thru channels to the Safety/Risk Management Department. The unsafe acts of persons and the unsafe conditions that cause accidents can be corrected only when they are specifically known and reported. This report is to be printed in ink and returned to Training/Personnel by the end of the work shift during which the accident occurred.

1. NAME OF INJURED EMPLOYEE: ______________________ S.S.# ____________

2. HOME ADDRESS: ______________________________

3. PHONE NUMBER: ____________ D.O.B: __________ SEX: ____ MARITAL STATUS: __________

4. NUMBER OF DEPENDENTS UNDER 18: ________

5. DEPARTMENT: ______________ JOB TITLE: ______________

6. EMPLOYEE PAYROLL #: ________ DATE HIRED: ____________ YEARS IN PRESENT POSITION: ________

7. ~~AVERAGE BI-WEE~~KLY SALARY FOR THE YEAR PRECEDING THE INJURY: $__________ (handwritten above: HOLY. RATE)

8. DATE OF INJURY: ____________ TIME OF INJURY: ________ AM/PM

9. WAS EMPLOYEE ABLE TO CONTINUE WORK?: ________

10. LAST DAY EMPLOYEE WORKED: ____________ DATE RETURNED TO WORK: ____________

11. WAS FIRST AID GIVEN?: ____ IF YES, BY WHOM?: ______________

12. ADDRESS/LOCATION WHERE INJURY OCCURRED: ______________

13. WAS EMPLOYEE OFFERED MEDICAL ATTENTION?: ____ IF NO, WHY?: ______________

____

14. NAME/ADDRESS OF PHYSICIAN: ______________

15. DATE FIRST TREATED: ____________

NOTE: IF MEDICAL TREATMENT IS RENDERED BY ANY PROVIDER OTHER THAN *OMEGA* YOU MUST COMPLETE CONSENT TO RELEASE MEDICAL INFORMATION FORM.

16. IS OR HAS EMPLOYEE BEEN HOSPITALIZED?: ______ IF YES, DATE HOSPITALIZED: ____________

17. NAME/ADDRESS OF HOSPITAL: ______________

18. NATURE OF INJURY AND BODY PART AFFECTED (BE SPECIFIC): ______________

____

19. WHAT SPECIFIC TASK WAS THE EMPLOYEE PERFORMING WHEN INJURY OCCURRED?:

____

____

20. IN YOUR OPINION WAS THE INJURY WORK-RELATED?: ______ IF NO, GIVE REASONS: ______________

____

(OVER)

21. WHAT, IF ANYTHING, DID THE EMPLOYEE DO UNSAFELY: ______________________________

____

____

22. WHAT HAZARDOUS CONDITIONS OR LACK OF PROTECTION CONTRIBUTED?: ______________

____

23. WAS THIS INJURY PREVENTABLE?: ______________

24. WHAT ACTION HAVE YOU TAKEN OR DO YOU PROPOSE TAKING TO PREVENT SIMILAR ACCIDENTS?: __________

____

25. WAS THERE VEHICLE DAMAGE OR OTHER DAMAGE TO CITY PROPERTY?: ______ IF YES, COMPLETE THE APPROPRIATE ACCIDENT REPORT (SEE REVISED VA785).

26. WAS A PRIVATE CITIZEN ALSO INVOLVED IN THIS ACCIDENT/INJURY?: ________ IF YES, GIVE NAME AND ADDRESS:

____

27. DID EMPLOYEE NOTIFY MEDICAL FACILITY THAT HE/SHE WAS AN *OMEGA* PATIENT? ______

28. DATE AND TIME *OMEGA* WAS NOTIFIED: ______________________________

STATE HOW INJURY HAPPENED (WHO/WHAT/WHERE/WHEN/WHY): ______________________________

____

____

____

____

NAMES OF WITNESSES TO INJURY: ______________________________

____

COMMENTS: ______________________________

____

____

____

____

SUPERVISOR'S SIGNATURE ______________________________ DATE: ______________

SIGNATURE OF REVIEWING DEPARTMENT HEAD ______________________________ DATE: ______________

Attach copies of medical treatment, return to work slip, and copies of medical chart if possible (outside of *Omega* network).