SUPERVISOR'S
CHECK LIST

Supervisor

Employee Name: _____ Date: _____

Department: _____

Employee #:_____

☐ **New Injury ____ Recurrence ____**

☐ **WC 207 First Report of Injury Form**

☐ **WC 207-1 Supervisor Accident Report**

☐ **Notified the Office of Human Resources on_____.**
(Date)

☐ **Employee received Worker's Compensation reporting packet**

Supervisor Name: _____

Return this packet to Francesca Poole in the Office of Human Resources. Retain a copy for your file.

Print Form

DAS

First Report of Injury WC 207

Reference No:

Central Office use only:
Incident No:

Claim No:

The Supervisor must complete this form with the employee and then forward it to your Agency's Worker's Compensation Specialist within 24 hours after the incident.

1. AgencyLocationCode	2. Division/Region			
CSU 85000	Southern Connecticut State University - Department of _____			
3.SSN	4.Employee Number	5.Name of Injured Worker (First) (Last) (MI)		
6.Home Address (City or Town) (State) (Zip)		7.Home Telephone	8.Date of Birth	9.Sex
10.Job Classification		11. Date of Hire	12.Date of Incident	13.Time of Incident
14.Time Employer Notified	15.Date Employer Notified	16. Was Injury Fatal? YES NO		17. Date of Fatality

18. How Did the Injury Occur?

19. Type of Injury	20. Body Part(s) Affected	21. Category of Illness or Injury
22. Did Injury Occur on Employer Premises? ☐ YES ☐ NO	23. Location Injury Occured	
24. Injured Worker Seeking Medical Treatment ☐ YES if yes complete question 25 NO ☐	25. Medical Care Provided By: (Physician Name and Address)	

26. Were There Any Witnesses to the Injury?
(If yes, give name, address and phone.)

27. To Whom Was Injury Reported? (Name) (Title)

28. **SUPERVISOR CONTACT INFO** Please Print

Name:

Work Phone:

Best Time to Contact:

29. Signature of Supervisor (or other Designated Authority)

I HAVE REVIEWED THE ABOVE FORM FOR COMPLETENESS

SUPERVISORS REPORT ALL INJURIES - CALL 1-800-828-2717

Reviewed 4/2014

Supervisor's Accident Investigation Report 207-1

The Supervisor must complete this form with the employee and then forward it to the Human Resources office, along with the 207 report, within 24 hours after the incident.

GENERAL INFORMATION

Employee Name	Date of Incident	Location of Incident
Job Title	Time of Incident	Medical Treatment? ☐ ER ☐ First Aid ☐ None ☐ Walk-In ☐ Ambulance ☐ Other
Nature of Injury		

INCIDENT DESCRIPTION: _____

_____

_____

TYPE OF INCIDENT: (check most appropriate, define other if checked)

- ☐ Assault by public
- ☐ Caught in/on/between
- ☐ Shoved by or against an object
- ☐ Contact with heat/cold/chemical
- ☐ Motor Vehicle Accident
- ☐ Slip/Trip/Fall
- ☐ Lifting/Material Handling
- ☐ Foreign body in eye
- ☐ Cumulative trauma
- ☐ Repetitive motion
- ☐ Cut/laceration/puncture
- ☐ Exposure (air quality, etc.)
- ☐ Other

CAUSES/CONTRIBUTING FACTORS *Check all that apply*

CONDITIONS

- ☐ Hazardous process
- ☐ Weather conditions
- ☐ Equipment not available
- ☐ Poor housekeeping
- ☐ Equipment malfunction
- ☐ Ergonomic set-up
- ☐ Floor/ground condition
- ☐ Poor lighting
- ☐ Poor design
- ☐ Carpet/mat
- ☐ Chemicals/cleaning agents
- ☐ Improper PPE
- ☐ Lack of training

BEHAVIORS

- ☐ Failure to follow safety procedure
- ☐ Failure to use PPE
- ☐ Improper technique
- ☐ Using equipment unsafely
- ☐ Inappropriate dress or footwear
- ☐ Failure to obtain assistance
- ☐ Working at unsafe speed
- ☐ Performing task without knowledge/failure to ask
- ☐ Failure to recognize unsafe condition
- ☐ Not in scope of duties
- ☐ Unsafe body mechanics
- ☐ Employee attitude on safety
- ☐ Horseplay
- ☐ Failure to use lookout/tagout
- ☐ Inattention/disfunction
- ☐ Poor judgement responding to unsafe condition
- ☐ Other

ACTION PLAN TO PREVENT RECURRENCE

- ☐ Reinforce employee accountability for safety
- ☐ Monitor work practices
- ☐ Work orders written
- ☐ Maintenance work order written
- ☐ Procedures revised
- ☐ Referrals made
- ☐ Apply OSHA program and manuals
- ☐ Additional training
- ☐ Hepatitus B vaccine
- ☐ Renew bloodborne training
- ☐ Renew hazmat training
- ☐ Ergonomic set-up evaluation
- ☐ Air quality consultation
- ☐ MVA= ☐ Local or ☐ State Investigation
- ☐ Other

MANAGER SIGNATURE:	PRINT NAME:	DATE:
SUPERVISOR SIGNATURE:	PRINT NAME:	DATE:

white copy - Agency pink copy - Agency Human Resources yellow copy - DAS Human Resources