WORKSITE
EMPLOYEE LEASING
Work.Simplified.

SUPERVISOR'S REPORT OF INJURY

Please complete and fax this form within 24 hours of injury to 866.782.1406

EMPLOYER INFORMATION

Client Number:	Client Name:
Contact Person:	

EMPLOYEE INFORMATION

Employee Name:	Date of Birth:
Social Security Number:	Daytime Phone:

ACCIDENT INFORMATION

Date of Accident:	Time of Accident:
Where did the accident occur?	
Describe the work being done and how the accident occurred:	
Will the employee be paid in full for the day of the injury? ❍ Yes ❍ No	
Did the employee return to work? ❍ Yes ❍ No	If yes, date returned:
Were there any witnesses to the accident? ❍ Yes ❍ No	
If yes, please list witness names:	

INJURY INFORMATION

Describe the type of injury in detail (please be specific):
Please list any pre-existing conditions that may apply:
Is there any doubt or question as to the validity of the injury? ❍ Yes ❍ No

TREATMENT FACILITY INFORMATION

Name:	Phone:
Address:	

Please provide all notes provided by treating facility

REFUSAL OF TREATMENT

Did the employee refuse treatment? ❍ Yes ❍ No	
Did the employee refuse a drug screen? ❍ Yes ❍ No	
Employee Signature:	Date:
Supervisor Signature:	Date:

WELCO USE ONLY

Received By:	Processed By:
Date:	Date: