**SUPERVISOR’S FIRST REPORT OF INJURY OR ILLNESS**

This form must be completed and signed by the supervisor or designated representative, not the employee/ students, and must be submitted *within 7 days* to OR-NSU via email or in-person delivery.

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| Name: | | | Employee ID: | | | Date of Birth: | | Gender: Male Female |
| Employee’s Work Telephone Number/Department Name: | | | | Home/Mailing Address: | | | | |
| Marital Status:  Married Widowed Separated  Single Divorced | | | Number of Dependent Children: | | | Spouse’s Name: | | |
| Treating Doctor’s Name (if medical treatment involved): | | | Clinic Address: | | | Telephone Number: | | |
| Date of injury (m-d-y): | | Time of injury: AM PM | | | | Date Lost Time Began (if applicable): | | |
| Type of Injury: (example: sprain, burn, contusion, laceration, fracture, puncture) | | | | | | Part of body injured or exposed: (Please be specific – e.g. right middle finger, left ankle, upper back) | | |
| Describe in detail how the accident occurred: (Describe the work process the employee was engaged in. Give the purpose of the function or task, describe how the injury occurred, and explain the cause). Attach additional sheets if necessary: | | | | | | | | |
| Was the employee doing his or her regular job?  YES NO | Location of accident: Building #: | | | | Room No.: | | Area: (hallway, office, parking lot, etc.) | |
| Cause of injury: (fall, tool, machine, etc.) | | | | | | List Witnesses: (Name/Phone #) | | |
| Return to work date: | | | Did employee die?  YES NO | | | Supervisor’s Name: | | Phone #: |
| Length of service in current position:  Years \_\_\_\_\_\_ Months \_\_\_\_\_\_ | | | Length of Service in Occupation  Years Months | | | | | |
| Employee’s Title: | | | | | Number of hours of sick/vacation accrued on date of injury:  Sick hrs. Vacation hrs. | | | |
| Do you agree with the employee’s description of the accident? YES NO | | | | | | | | |
| If no, explain: | | | | | | | | |
| Was safety equipment provided? (if applicable) YES NO | | | | | Was safety equipment used (if applicable)? YES NO | | | |
| If no, explain: | | | | | | | | |
| Action taken to prevent this type of accident from recurring **(must be completed):** | | | | | | | | |
| Name of Supervisor: | | | Title: | | | Work phone number: | | |

For any questions, email to [bio.safety@northsouth.edu](mailto:bio.safety@northsouth.edu)