Central Region School Insurance Group

SUPERVISOR'S REPORT OF EMPLOYEE INJURY/ILLNESS

Employee Name:		
Occupation:		
Work Site:		
Date of Injury:		
Time of Injury:		
Accident Location:		
Type of Injury:		
Date Reported:		
Time Reported:		
Medical Facility Employee Was Sent To:		
Did worker leave work?	YES	NO
Did worker return to work?	YES	NO
Describe how the accident occurred		
Name of Witnesses:		
What steps have been taken to prevent similar accidents?		
Supervisor Signature		Date:
Date sent to District Office:		

Please send this report to:

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