Utah County
HEART of UTAH

WORKERS' COMPENSATION SUPERVISOR'S REPORT

Upon knowledge of an accident resulting in injury, the immediate supervisor shall **notify Human Resources immediately**, and complete this form and **send it to the Human Resources Department within 24 hours from date of injury**.

Injured Employee's Name:		Position/Department:	
Date of Injury:	Time of Injury:	Date Reported to You:	Time Reported:
Address where accident happened:			
Witnesses of the accident:			
Specific activity being performed when the accident occurred:			
Describe how the injury happened: (Be descriptive)			
Type of Injury:		Part of Body Affected: (Be descriptive.)	
Were safeguards or safety equipment provided? ☐ Yes ☐ No Were they used? ☐ Yes ☐ No			
Possible preventative measures:			
Result of Accident: (Check all that apply.) ☐ Death ☐ Days away from work ☐ Restricted work duty ☐ Initial examination only			
Provide all medical documentation of ***restricted work duty or return to regular duty without restrictions*** *to the Human Resources Department.* *If accident results in the employee missing more than 3 consecutive days, FMLA leave paperwork will need to be completed by the employee so that the leave can be designated as FMLA.*			
Immediate Supervisor's Signature:		Date:	
Print Immediate Supervisor's Name:		Supervisor's E-mail:	
Immediate Supervisor's Telephone Number:			