

THE ART INSTITUTE OF CHICAGO

SUPERVISOR'S REPORT OF EMPLOYEE-RELATED INJURY

Complete this form and submit it to **Human Resources Records Office** within 4 hours of an injury. Should you have questions, need assistance with medical transportation or finding an authorization form for treatment, call Human Resources Records at 9-3379.

Check one: First Aid Medical Treatment Lost Time Injury
 Other, specify _____

Classification of injured employee: Staff Faculty Student Worker

Name of injured employee _____ Employee ID _____

Employee's work number _____ Employee's home (or cell) number _____

Time employee began work on the date of the injury _____ AM/PM

Name of supervisor _____ Supervisor's work number _____

Did employee miss any work? Yes No If yes, day last worked _____

Did the injury occur on the Art Institute's premises? Yes No

Date and time of injury _____ AM/PM
Date Time

Address of injury _____
Street Address City

Location where injury occurred _____

What specific activity was the employee engaged in when the injury occurred? Describe the activity as well as the tools, equipment or materials in use at the time of the injury.

How did the injury occur? List any possible causes or contributing factors.

What was the injury or illness? Be specific when listing the body part(s) affected and explain how it was affected (i.e. strained lower back or puncture wound on finger).

What object or substance directly harmed the employee?

State your ideas on how future injuries of this type could be prevented. Describe changes or improvements in equipment, procedures, buildings, training, or personal protective equipment needed.

Did Employee refuse medical treatment? Yes No

Was the Employee's Supervisor notified? Yes No Date and Time the Employee's Supervisor notified _____

Was an ambulance called? Yes No If yes, name of service _____

If treatment was given at the worksite, list where it was given and by whom _____

If medical treatment was received off-site, list the name and address of the physician/healthcare professional _____

Street Address City

Witnesses to injury _____
(Attach any witness statements to this injury report)

Note: The employee's supervisor should submit this injury report to Human Resources Records, and retain a copy for their files.

Employee signature _____ Department _____

Supervisor's signature _____ Date of report _____

Human Resources signature _____