



# SUPERVISOR'S REPORT OF INJURY / ILLNESS



PROJECT NAME: \_\_\_\_\_ JOB #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NAME OF INJURED PERSON: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

WHAT WAS EMPLOYEE DOING AT TIME OF INJURY? \_\_\_\_\_

\_\_\_\_\_

DESCRIPTION OF ACCIDENT: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NATURE AND EXTENT OF INJURY: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_ TIME OF ACCIDENT: \_\_\_\_\_

UNSAFE CONDITION OR ACT: \_\_\_\_\_

WHAT I HAVE DONE TO CORRECT THE SITUATION? \_\_\_\_\_

\_\_\_\_\_

ACCIDENT WITNESS ONE: \_\_\_\_\_ TELEPHONE NO.: \_\_\_\_\_

ACCIDENT WITNESS TWO: \_\_\_\_\_ TELEPHONE NO.: \_\_\_\_\_

WHEN AND WHERE WAS MEDICAL ATTENTION RECEIVED: \_\_\_\_\_

\_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

NAME OF RAND CONSTRUCTION CORPORATE OFFICE SUPERVISOR NOTIFIED:  
\_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

SUPERVISOR'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

EMPLOYEE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(\*SUBMIT ORIGINAL COMPLETED REPORT TO CORPORATE OFFICE WITHIN TWO WORKING DAYS)