CHARLES COUNTY GOVERNMENT
EMPLOYEE/SUPERVISOR REPORT OF INJURY

NAME OF INJURED EMPLOYEE:		SSN:
HOME ADDRESS:		
HOME/CELL PHONE:		WORK PHONE:
POSITION:	DEPARTMENT:	DIVISION:
DATE OF INJURY:		TIME OF INJURY:
LOCATION OF ACCIDENT/INJURY:		
DESCRIBE TYPE OF WORK BEING PERFORMED AND HOW INJURY OCCURRED:		
DESCRIBE BODILY INJURY SUSTAINED (Be specific about location on body):		
WITNESS(ES) AND PHONE NUMBERS:		
SUPERVISOR NAME:		POSITION:
AFTER INVESTIGATION, WHAT DO YOU THINK WAS THE CAUSE OF INJURY?		
RECOMMENDATION(S) FOR CORRECTIVE/PREVENTIVE MEASURES:		

TOP MANAGEMENT REVIEW

NAME:	POSITION:	DATE:
NAME OF PERSON ASSIGNED:	POSITION:	PHONE NUMBER:

This form shall be completed for all work related injuries/illnesses and forwarded to the Safety Office with the First Report of Injury form.