

**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 Central Services Office with the First Report of Injury form.