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? IF EMPLOYEE REFUSED TREATMENT, PLEASE EXPLAIN.		
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.