

SUPERVISOR REPORT OF INCIDENT/INJURY

EMPLOYER: EAST MISSOURI ACTION AGENCY		EMPLOYER POLICY #: 1015078	
EMPLOYER CONTACT NAME: TERI SCHWEISS		EMPLOYER PHONE #: 573-431-5191 x 1108	
NAME OF INJURED EMPLOYEE (<i>LAST, FIRST, MIDDLE INITIAL</i>)			
PROGRAM		JOB TITLE	
RATE PER HOUR	DAYS WORKED PER WEEK	HOURS WORKED/DAY	TIME BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM
DATE OF INCIDENT	TIME OF INCIDENT <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE REPORTED	INCIDENT LOCATION
EXTENT OF INJURY			
TREATING MEDICAL FACILITY/DOCTOR (<i>Name & Address</i>)			
BODY PART INJURED (<i>Lt ring finger, Rt ankle, etc</i>)			
NATURE OF INJURY (<i>Scratch, Cut, Bruise, etc</i>)			
WHERE AND HOW DID ACCIDENT HAPPEN?			
WHAT WAS EMPLOYEE DOING AT TIME OF ACCIDENT?			
LIST ALL EQUIPMENT, MATERIALS, OR CHEMICALS USING WHEN INCIDENT OCCURRED			
WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?			DATE RETURNED TO WORK
WERE THEY USED?			
ANY OTHER WITNESSES?		WERE THERE OTHERS INJURED?	
NAME:	PHONE:	NAME:	
NAME:	PHONE:	NAME:	
MEASURES RECOMMENDED TO PREVENT A SIMILAR ACCIDENT			
SUPERVISOR'S SIGNATURE:		DATE:	

MAIL or FAX COMPLETED FORM TO:

TERI SCHWEISS
PO BOX 308
PARK HILLS, MO 63601

FAX: 573-431-6773