PO Box 1209, Piscataway, NJ 08855
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SUPERVISOR REPORT – WORKERS COMPENSATION CLAIM

- SUBMIT AS A SUPPLEMENT TO THE ORIGINAL FIRST REPORT OF INJURY
- TO BE COMPLETED BY EMPLOYEE'S DIRECT SUPERVISOR

Supervisor Name: _____

Employer/Fund Member: _____

Address: _____

Phone: _____

1. Employee Name: _____
2. Department: _____
3. Date, Time and Location of Occurrence: _____
4. Type of Injury: _____
5. Do you usually supervise this individual? Yes ____ No ____
   If No, Explain: _____
6. Was accident immediately reported? Yes ____ No ____
   If No, Explain: _____
7. Was employee working: Alone _____ With Crew _____
8. Did you physically inspect the area where the injury occurred? Yes ____ No ____
   If No, Explain: _____
9. Any unsafe conditions or unusually hazards present? Yes ____ No ____
   If Yes, Explain: _____
10. Was employee wearing back support? Yes ____ No ____
    If No, Explain: _____
11. Evidence of horseplay: Yes ____ No ____
    If Yes, Explain: _____
12. Evidence of intoxication Yes ____ No ____
    If Yes, Explain: _____
13. Evidence of drug abuse Yes ____ No ____
    If Yes, Explain: _____
14. Are you satisfied that the accident/injury occurred as described above? Yes ____ No ____
    If No, Explain: _____
15. What additional training may have prevented this accident? _____
16. What additional training would you like Fund's Safety Director to provide? _____
17. What circumstances contributed to this accident? _____
18. What actions contributed to this accident? _____
19. What changes in circumstances or actions could have prevented this accident? _____
20. Your actions taken to minimize the chance of a recurrence? _____
21. Your future plans to minimize the chance of a recurrence? _____
22. Would you like to speak to any Fund Professional? Yes ____ No ____
    If Yes, please list: _____

SIGNATURE: _____

DATE: _____