UNIVERSITY OF MINNESOTA DULUTH

WORKERS' COMPENSATION

Supervisor Incident Investigation Report

EMPLOYEE INFORMATION

University Campus/Location	Department & Position	☐ Regular Employee ☐ Student Employee
Employee Name (Last, First, MI)		
Employee Home Address	Employee Phone Number Home: Work:	

ACCIDENT INFORMATION

Date of Incident	Time of Incident	Date Supervisor Notified	Did the employee lose time from work?	Date Returned to Work

Accident Location: Describe in detail the specific location where employee was injured:
Describe in detail what the employee reported to you. Be as specific as possible about what was said:
What areas of the body did the employee complain of (left hand, neck, back, etc.)? Be specific:
Employee activity and work process at the time of incident:
Equipment or Materials in use at time of injury:
Causal Factors: List any conditions, hazards, lack of personal protective equipment, at risk behaviors contributing to the accident.
Corrective Actions Taken:
Reasons for not implementing corrective actions:

Witness Name	Witness Phone	Witness Name	Witness Phone

MEDICAL TREATMENT

Initial Treatment

☐ No Medical Treatment ☐ Minor First Aid By Employer ☐ Minor Clinic/Hospital

☐ Emergency Care ☐ Hospitalized > 24 Hours ☐ Future Major Medical Lost Time Anticipated

Name of Treating Physician, Clinic or Hospital

Supervisor Name	Supervisor Phone Number
Supervisor Signature	Date

Supervisor must submit completed form within 24 business hours after notification of the injury. Forward completed form to UMD Workers' Compensation Coordinator, 255 Darland Administration Building (FAX: 218-726-7505). Contact UMD Workers' Compensation Coordinator at 726-6827, if you have any questions.

*****TO SUPERVISOR: PLEASE KEEP A COPY OF THIS REPORT FOR YOUR RECORD*****

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