MERCER COUNTY EDUCATIONAL SERVICE CENTER

# SUPERVISOR'S INVESTIGATION REPORT

**Employee Name:** ______________________ **Date of Injury:** _______________ **OSHA Log #**__________

OSHA 301 Info in Bold

**Was the employee killed as a result of the accident? If yes, indicate date of death:**______________________

Were there any witnesses to this injury? ☐ **Yes** ☐ **No**
If yes, witness statements should be attached.

Was the injury a result of horseplay, under the influence of drugs, or purposely self-inflicted? ☐ **Yes** ☐ **No**
If yes, please specify details on the back of this form or on another page.

Has there been any recent disciplinary action taken against this employee? ☐ **Yes** ☐ **No**
If so, please describe:

______________________________________________________________________

______________________________________________________________________

Has the employee submitted medical documentation for the injury? If so, please attach. ☐ **Yes** ☐ **No**

**Was the employee treated in an emergency room or similar?** ☐ **Yes** ☐ **No**

**Was the employee hospitalized overnight as an in-patient?** ☐ **Yes** ☐ **No**

**If known, please provide us with the name, address and telephone number of attending physician and/or hospital:**

Physician:________________________________ Facility:________________________________

Has the employee returned to work? ☐ **Yes** ☐ **No**
Last Day worked ______________________ Returned to work _______________

Does the employee have restrictions to duty? ☐ **Yes** ☐ **No** Applicable dates:____________________

Is the employee performing their full duties? ☐ **Yes** ☐ **No**

Was the employee given a prescription by the physician? ☐ **Yes** ☐ **No**

**Employee Date of hire:** ______________________

Have the conditions that caused the accident been controlled? ☐ **Yes** ☐ **No**
Describe action taken to prevent the accident in the future:____________________________________________

______________________________________________________________________

With the information you have, would you recommend the claim be accepted? ☐ **Yes** ☐ **No**
If no, why? ____________________________________________________________

**Completed by:**

__________________________________________ ______________________________
Supervisor Signature/Title/Phone Date

__________________________________________ ______________________________
Workers' Compensation Coordinator Signature Date

**Please attach completed incident reports, witness statements and any accumulated medical bills and information. Additional comments may be noted on the reverse side.