

SUPERVISORS INCIDENT REPORT

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYER
Fax or Email this completed form to FAS (972) 930-9479 or CLAIMS@FASTPA.COM

EMPLOYER NAME: _____	Policy# _____	
LOCATION: (If different from above) _____	LOCATION NO.: _____	
DEPARTMENT: _____	JOB TITLE: _____	DATE OF HIRE: ____/____/____
SCHEDULED DAYS/WEEK: _____	SCHEDULED HOURS/DAY: _____	HOURLY RATE: \$ _____
TIME LOST FROM WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>	FIRST DAY OF LOST TIME: ____/____/____	
DATE RETURNED TO <input type="checkbox"/> FULL <input type="checkbox"/> MODIFIED / DUTY: ____/____/____		

EMPLOYEE INFORMATION:

NAME: _____ SOCIAL SECURITY NO: _____
HOME ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ PHONE: (____) _____
GENDER MALE FEMALE PREFERRED LANGUAGE IF OTHER THAN ENGLISH: _____

BASIC INJURY INFORMATION

DATE OF INCIDENT: ____/____/____ DAY OF WEEK: _____ TIME OF INCIDENT: _____ A.M. P.M.
DATE REPORTED INCIDENT: ____/____/____ DAY OF WEEK: _____ TIME REPORTED INCIDENT: _____ A.M. P.M.
NAME OF SUPERVISOR WHEN INJURY OCCURRED: _____ CONTACT PHONE #: (____) _____
DESCRIBE NATURE OF THE EMPLOYEE'S INJURY: _____
BODY PART(S) INVOLVED: _____
DESCRIBE EQUIPMENT INVOLVED (IF ANY): _____

WITNESS INFORMATION (IF NONE PLEASE INDICATE NONE)

NAME OF WITNESS: _____ HOME PHONE: (____) _____
HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
EMPLOYEE? YES NO TITLE: _____ DEPT: _____ WORK PHONE: (____) _____
NAME OF WITNESS: _____ HOME PHONE: (____) _____
HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
EMPLOYEE? YES NO TITLE: _____ DEPT: _____ WORK PHONE: (____) _____

MEDICAL PROVIDER

NAME OF CLINIC/HOSPITAL/PHYSICIAN: _____ PHONE: _____
IF NOT A DESIGNATED PROVIDER, PLEASE COMPLETE THE FOLLOWING -
ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SIGNATURE OF SUPERVISOR/MANAGER COMPLETING REPORT

Supervisor/Manager Name - Printed
X _____
Supervisor/Manager Signature

Phone

Date