

SUPERVISORS INFORMATION FORM

Fax or Email to: FAS (972) 930-9479 or CLAIMS@FASTPA.COM
P O BOX 2309, Addison, TX 75001-2309

EMPLOYER NAME: _____
INJURED EMPLOYEE: _____
DATE OF INCIDENT: _____ SCHEDULED HOURS/DAY: _____
HOURLY RATE: \$ _____ SCHEDULED DAYS/WEEK: <u>S M T W T F S</u> TIME LOST? YES <input type="checkbox"/> NO <input type="checkbox"/>
DATE RETURNED TO WORK: _____ FULL DUTY? YES <input type="checkbox"/> NO <input type="checkbox"/>

NAME OF INJURED EMPLOYEE'S SUPERVISOR WHEN INJURY OCCURRED: _____

Phone : _____

SIGNATURE OF SUPERVISOR/MANAGER COMPLETING REPORT

Supervisor/Manager Name - Printed

Phone:

X

Supervisor/Manager Signature

Date