FUSD CLAIM # _____

POLICE RPT# _____

DATE STAMP RECEIVED
(FOR OFFICIAL USE ONLY)

U.S. Mail Hand Delivery Other

FUSD SUPERVISOR'S REPORT OF EMPLOYEE INJURY

TO BE COMPLETED BY EMPLOYER

Employee Name: _____ Age: _____

Occupation: _____

Date of Injury: _____ Time of Injury a.m. ☐ p.m. ☐

Date of Reported: _____ Time of Injury a.m. ☐ p.m. ☐

Accident Location _____

Type of Injury _____

Medical Facility _____

Did Injured Leave Work _____

Did Injured Return to Work _____

1. Describe how accident occurred _____
2. Name of witnesses _____
3. Steps taken to prevent similar accidents _____
4. Is employee going to seek outside medical attention _____

Supervisor's Signature _____ Date _____

Please forward completed form to the Risk Management department for further processing.