CITY OF SAINT PAUL

SUPERVISOR'S SAFETY REPORT — INJURY OR AGGRAVATION

THIS FORM MUST BE COMPLETED by the supervisor for each work-related injury or aggravation within 24 hours.

DEPARTMENT_____ **DIVISION**_____ **ACTIVITY CODE**_____

1 Name of injured employee_____

2 Date of Injury_____ Was time lost from work? ☐ Yes ☐ No

3 Was site of injury visited? ☐ Yes ☐ No Date of site visit_____

4 What can be done to prevent a similar occurrence?_____

5 Was any corrective action taken? ☐ No ☐ Yes--Describe_____

6 Did another person, tools, or equipment contribute to this injury? ☐ No ☐ Yes--Identify and describe how_____

7 Was safety equipment available? ☐ No ☐ Yes ☐ Does not apply

8 Was safety equipment in use? ☐ No ☐ Yes ☐ Does not apply

9 At the time of the injury, how many hours had the employee been working?_____

10 If injury occurred outdoors, describe the weather conditions at the time_____

YOUR ROLE IN A SPEEDY RETURN-TO-WORK IS OF UTMOST IMPORTANCE. IF ABSENCE FROM WORK EXCEEDS THREE CALENDAR DAYS, PERSONAL CONTACT IS WARRANTED.

A. Ask about recovery status and progress.
B. Is employee satisfied with medical care to date?
C. Does employee have any questions?
D. What is estimated return-to-work date?
E. Assure employee that his/her job is not in jeopardy because of injury, and that you and co-workers are anxious for employee's return-to-work. Find out if light-duty will speed return-to-work.
F. Discuss other pertinent issues and questions.

Follow-up calls should take place every week until return-to-work.

Information obtained from employees should be shared with departmental Workers' Compensation liaison and the City's Workers' Compensation staff at (651) 266-6500.

If you or the employee have any questions, please call the Workers' Compensation staff at (651) 266-6500.

11 Any additional information regarding the case_____

Supervisor's Name_____ Supervisor's Phone_____

Supervisor's Signature_____ Date_____

WHITE--Workers' Compensation Administrator YELLOW--Department PINK--Supervisor