**Injury Data Collection Form for Supervisors**

**Revised January 1, 2020**

**Instructions: Injured employee’s supervisor immediately completes form following work related injury and sends to agency staff responsible for reporting work related injury to third party administrator (CCMSI) via iCE web portal.**

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| **Employer Information** | | |
| **State Agency/Department:** |  | |
| **Unit of State Agency/Department:** | | **Unit Location:** |

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| **Claimant’s Personal Information** | | | | | | |
| **Claimant ID Number:**  **Type: □ Social Security Number □ Permanent Resident ID □ Employer Visa ID □ Federal ID** | | | | | | |
| **Last Name:** | | | **First Name:** | | | **Middle Name:** |
| **Street Address:** |  | | | | | |
| **City:** |  | | **State:** | **Zip Code:** | | **County:** |
| **Work Phone:** | | **Work Email:** | | | **Occupation:** | | |
| **Home Phone:** | | **Cell Phone:** | | | **Personal Email:** | | |
| **Date of Birth:** | | **Marital Status:** | | | **Gender:** | | |

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| **Incident Information** | | | | | | |
| **Date of Injury:** | | **Time of Injury:** | | | | **Date Injury Reported to Supervisor:** |
| **Describe fully how injury occurred and what employee was doing at the time of the injury:** | | | | | | |
| **What part and side of the body was injured?** | | | | | | |
| **Client assault: □ Yes □ No** | **Client Caused: □ Yes □ No** | | | | **Salary Continuation eligible employee: □ Yes □ No** | |
| **Time employee started work the day of the injury:** | | | | | **Did injury occur on employer’s premises? □ Yes □ No** | |
| **Did employee return to work? □ Yes □ No** | | | **Date and time employee returned to work?** | | | |
| **Where did injured employee go for medical treatment (Facility name, address, phone number)?** | | | | | | |
| **Did injury require hospitalization? □ Yes □ No** | | | | **Did injury require ER visit? □ Yes □ No** | | |

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| **Form Completed By:** | | |
| **Supervisor Name:** | **Supervisor Phone:** | **Supervisor Email:** |