

**SUPERVISOR'S REPORT OF INDUSTRIAL INJURY  
ORIGINAL TO YOUR MAIN OFFICE FILE**

EMPLOYER Any Company U.S.A.  
MAILING ADDRESS 1234 Any Street, Somewhere, America 00001  
POLICY NO. 000000-1 EXPIRATION DATE 01 | 01 | 99  
MO DA YR

NAME OF INJURED Sherm Akin  
HOME ADDRESS 111 Any First Street, Somewhere, America 00001  
JOB TITLE Adhesive spreader DEPT. Glue Room  
BIRTH DATE 02 | 29 | 48 SOC. SEC. NO. 123-45-6789  
MO DA YR

INJURY DATE 01-01-81 TIME 4:00 AM PM

NATURE OF INJURY Strain  
(SCRATCH, CUT, BRUISE, ETC.)  
PART OF BODY INJURED Lower left back area  
(LEFT FINGER, RIGHT ANKLE, ETC.)  
NAME OF DR. OR HOSPITAL Uhurtit Memorial  
WHERE DID ACCIDENT HAPPEN? Delivery area at shop

HOW DID ACCIDENT HAPPEN? (STATE SPECIFIC JOB BEING DONE AND WHAT WENT WRONG. INCLUDE MACHINE/TOOL OR OBJECT CONNECTED WITH ACCIDENT.)  
Was moving 5-gallon cans of liquid adhesive from delivery area to Glue Room storage area. When he lifted and twisted, with a can in each hand, he felt sharp pain in the back.

IF ACCIDENT WAS CAUSED BY NON-COMPANY PERSON OR BY FAULTY EQUIPMENT GIVE NAME AND ADDRESS

NAME OF WITNESSES Churri Sawitt

WHAT HAVE YOU DONE OR WILL YOU DO TO PREVENT A SIMILAR TYPE OF ACCIDENT? Moved adhesive storage area next to delivery area. Supplier will now deliver direct to new storage area. Purchased hand pump so small amounts needed each day can be pumped out daily.

EMPLOYEE'S SIGNATURE \_\_\_\_\_ DATE REPORTED \_\_\_\_\_

SUPERVISOR'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

REVIEWING MANAGER'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Supervisor — Send this copy to YOUR main office

**SUPERVISOR'S REPORT OF INDUSTRIAL INJURY**

EMPLOYER \_\_\_\_\_  
MAILING ADDRESS \_\_\_\_\_  
POLICY NO. \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_  
MO DA YR

NAME OF INJURED \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_  
JOB TITLE \_\_\_\_\_ DEPT. \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ SOC. SEC. NO. \_\_\_\_\_  
MO DA YR

INJURY DATE \_\_\_\_\_ TIME \_\_\_\_\_ AM PM

NATURE OF INJURY \_\_\_\_\_  
(SCRATCH, CUT, BRUISE, ETC.)  
PART OF BODY INJURED \_\_\_\_\_  
(LEFT FINGER, RIGHT ANKLE, ETC.)  
NAME OF DR. OR HOSPITAL \_\_\_\_\_  
WHERE DID ACCIDENT HAPPEN? \_\_\_\_\_

HOW DID ACCIDENT HAPPEN? (STATE SPECIFIC JOB BEING DONE AND WHAT WENT WRONG. INCLUDE MACHINE/TOOL OR OBJECT CONNECTED WITH ACCIDENT.)

IF ACCIDENT WAS CAUSED BY NON-COMPANY PERSON OR BY FAULTY EQUIPMENT, GIVE NAME AND ADDRESS

NAME OF WITNESSES \_\_\_\_\_

WHAT HAVE YOU DONE OR WILL YOU DO TO PREVENT A SIMILAR TYPE OF ACCIDENT? \_\_\_\_\_

EMPLOYEE'S SIGNATURE \_\_\_\_\_ HOME PHONE NO. \_\_\_\_\_ DATE REPORTED \_\_\_\_\_

SUPERVISOR'S SIGNATURE \_\_\_\_\_ SUPERVISOR'S PHONE NO. \_\_\_\_\_ DATE \_\_\_\_\_

REVIEWING MANAGER'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Supervisor — Send WHITE copy to YOUR main office.**