

CITY OF EL PASO
WORKERS' COMPENSATION PROGRAM
Completion and Distribution of Forms

SUPERVISOR'S REPORT OF ACCIDENT, INJURY, OCCUPATIONAL ILLNESS

1. Fax a copy to CAS at 903-509-1888 or scan directly to your assigned adjuster.
2. Send original and a copy to Insurance & Benefits.
3. Retain a copy.
4. **DO NOT** send a copy to LEGAL.

CITY OF EL PASO
Supervisor's Report of Accident, Injury, Or Occupational Illness

Department: _____ Division: _____
Date of Incident: _____ Reported To: _____
Date Reported: _____ Time Reported: _____

Name: (First) _____ (Initial) _____ (Last) _____

SSN: _____ Sex: _____ DOB: _____ Date of Hire: _____

Job Classification: _____ Time in Classification: _____

Type of Incident Injury Occupational Illness Non-Injury Incident Exposure Incident

Location of Incident (Address, shop, etc.) _____
Specific Location (front yard, bay #2, etc.) _____

Time Occurred: _____ AM PM Day of Week: _____
Worked Remainder of Shift: Yes No Time Shift Started: _____ AM PM
Employee was: Alone With Co-Worker Who: _____
Supervision at Time of Incident: Directly Supervised Indirectly Supervised Not Supervised
Specific Activity When Incident Occurred: _____
Was this a Normal Duty: Yes No Was Proper PPE Available: Yes No
Was PPE Used: Yes No

Describe What Happened: _____

Nature of Injury/Illness/Exposure: _____

Severity: First Aid Only Medical Treatment _____
 Refused Medical Treatment Referred to Infectious Disease Control Nurse
 Fatality
 No Lost Time Losing Time Now Time Lost to Date: _____

Property Damage: Yes No Type: _____
Vehicle Involved: Yes No Description: _____
Seat Belts Worn: Yes No

How can a similar incident be prevented from happening: _____

Supervisor: _____ Title: _____ Date: _____
Dept. Head Signature: _____ Date: _____