Claims

Claims Management of Missouri, LLC

Mgmt of MO

SUPERVISOR
Incident/Injury Report

SUPERVISOR NAME & DEPARTMENT	DATE OF INCIDENT	DATE INCIDENT REPORTED
INJURED EMPLOYEE NAME	PERSON INJURY REPORTED TO	
TIME OF INCIDENT ☐ A.M. ☐ P.M.	TIME INCIDENT REPORTED ☐ A.M. ☐ P.M.	
LOCATION OF INCIDENT	JOB INJURED EMPLOYEE PERFORMING	
TYPE OF INJURY ☐ NEAR MISS ☐ INJURY ☐ PROPERTY DAMAGE	WAS EMPLOYEE ON DUTY AT TIME OF INJURY? ☐ YES ☐ NO	
LOCATION OF INCIDENT	DID THE INJURY RESULT IN LOST TIME? ☐ YES ☐ NO	

WAS INJURY CAUSED BY A NON-COMPANY PERSON? ☐ YES ☐ NO OR BY FAULTY EQUIPMENT? ☐ YES ☐ NO

DESCRIPTION OF INJURY *(WHAT HAPPENED) – USE SEPARATE SHEET IF NEEDED*

DO YOU KNOW OF ANY WITNESSES? ☐ YES ☐ NO *IF YES, LIST NAME(S) AND HAVE THEM COMPLETE A WITNESS INCIDENT/INJURY REPORT*

REFERRED FOR MEDICAL TREATMENT? ☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY: ☐ OCCUPATIONAL MEDICINE CLINIC ☐ HOSPITAL EMERGENCY ROOM ☐ TRANSPORTED BY AMBULANCE

DO YOU THINK THE INCIDENT OCCURRED DUE TO AN UNSAFE CONDITION? ☐ YES ☐ NO OR DUE TO UNSAFE ACT? ☐ YES ☐ NO

DO YOU KNOW OF ANY OTHER SIMILAR INCIDENTS OCCURRING IN THE PAST? ☐ YES ☐ NO

DO YOU THINK THIS INCIDENT COULD HAVE BEEN PREVENTED? ☐ YES ☐ NO

PRINT NAME OF PERSON COMPLETING THIS REPORT

SIGNATURE OF PERSON COMPLETING THIS REPORT	CURRENT DATE

Fax or mail or e-mail completed form to:

MMMA-Claims Management of Missouri, LLC
16100 Chesterfield Pkwy. W., Ste. 210
Chesterfield, MO 63017-4817

Fax: (636) 537-1362
E-mail: claims@mmm-a.com