

SUPERVISOR Incident/Injury Report

SUPERVISOR NAME & DEPARTMENT		DATE OF INCIDENT		DATE INCIDENT REPORTED
INJURED EMPLOYEE NAME		PERSON INJURY REPOR	RTED TO	
TIME OF INCIDENT	И. Р.М.	TIME INCIDENT REPORT	ΓED	☐ A.M. ☐ P.M.
LOCATION OF INCIDENT	JOB INJURED EMPLOYEE PERFORMING			
TYPE OF INJURY NEAR MISS INJURY PROPERTY	WAS EMPLOYEE ON DUTY AT TIME OF INJURY? ☐ YES ☐ NO			
LOCATION OF INCIDENT	Driving	DID THE INJURY RESUL	T IN LOST TIME?	
WAS INJURY CAUSED BY A NON-COMPANY PERSON? 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?				
PRINT NAME OF PERSON COMPLETING THIS REPORT				
SIGNATURE OF PERSON COMPLETING THIS REPORT			CURRENT DA	TE
Fax or mail or e-mail completed form to: MMMA-Claims Management of Missouri, LLC 15450 South Outer 40 Road, Ste. 200 Chesterfield, MO 63017-4817				
	Fax: (636) 537-1362 E-mail: adjusters@mmm-a.com			