**Hall County Board of Education – Supervisor Report for Work Related Injury**

Fill in **ALL** information and return to Candy Thomas within (3) working days of the injury.

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| Employee Name |  | Social Security # |  |
| Job Title |  | Work Location |  |
| Full-Time |[ ]  Number of hours worked per day |  | Number of hours worked per Week |  |
| Part-Time |[ ]   |  |  |  |
| Was the injury reported to you? | Yes |[ ]  No |[ ]  If no, to whom? |  |
| Did you authorize the employee to seek medical care? | Yes |[ ]  No |[ ]   |
| What was the employee doing at the time of the injury? |  |
| Describe contributing factors (i.e.: weather, personal actions, another person, etc.) |  |
| How did the accident occur? |  |
| Did you inform the employee of the panel of physicians? | Yes |[ ]  No |[ ]  Did anyone witness this injury? | Yes |[ ]  No |[ ]
| If yes, please list the name of the witness and have the witness complete a written statement of what happened. |  |
| Did employee leave work as a result of this injury? | Yes |[ ]  No |[ ]  Did employee receive full pay for the date of injury? | Yes |[ ]  No |[ ]
| Did employee work the next scheduled work day following the injury? | Yes |[ ]  No |[ ]   |
| Has the employee returned to work? | Yes |[ ]  No |[ ]  If no, when is the employee expected to return? | Click or tap to enter a date. |

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| Supervisor Signature |  | Date | Click or tap to enter a date. |