**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. |