Arizona Counties Insurance Pool
1905 W. Washington St., Suite 200 Phoenix, AZ 85009 · (602) 452-4535 · FAX (602) 452-4517

SUPERVISOR'S REPORT OF INJURY INSTRUCTIONS

Injury—No Treatment Required

1. **SUPERVISOR** downloads and completes Supervisor Report of Injury Form (**do not** have employee fill out).

2. Have employee sign.

3. Supervisor to send copy to Risk indicating no treatment sought at this time. Instruct employee to return for copy of Report of Injury form if treatment is required.

4. Go to line 4 of the 'Treatment Required' instructions once employee requests copy of Report of Injury form.

Injury—Treatment Required

1. **SUPERVISOR** downloads and completes Supervisor Report of Injury Form (**do not** have employee fill out).

2. Have employee sign.

3. Give copy of Report of Injury form to employee. Keep a copy of form and forward (e-mail or FAX) to Risk without delay.

4. Provide Prescription form to employee.

5. Direct employee to appropriate facility **(ER is LAST RESORT)**.

6. Inform employee of light duty.

7. Require work status slip after all physician visits—turn into Risk.

SUPERVISOR'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND E-MAIL THIS REPORT TO RISK MANAGEMENT WITHIN 24 HOURS OF ACCIDENT

FATALITIES MUST BE REPORTED WITHIN 4 HOURS

MODIFIED DUTY IS AVAILABLE

Billing Address:
Arizona Counties Insurance Pool
1905 W. Washington St., Suite 200
Phoenix, AZ 85009

Risk Management Use Only

OSHA Case #: _____

Work Comp #: _____

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	BIRTH DATE

STREET ADDRESS (NUMBER & STREET)	CITY	STATE	ZIP	HOME TELEPHONE

MAILING ADDRESS (NUMBER & STREET)	CITY	STATE	ZIP

SEX — MALE ◯ FEMALE ◯

MARITAL STATUS — SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED ◯

EMPLOYER'S NAME	DEPT

ADDRESS (NUMBER & STREET)	CITY	STATE	ZIP	WORK TELEPHONE

Date of Injury	Time of Injury	Date Employer Notified of Injury	Date Employee Left Work	Date Returned to Work

Employee's Occupation (Job Title) When Injured

Address or Location of Accident	City	County	State	Zip

On Employer Premises?	Nature of Injury (Scratch, Cut, Bruise, etc.)	Fatal? Yes ◯ No ◯	Part of Body Injured

Will Treatment Be Sought?	If Yes, Where?

What was Employee Doing When Accident Occurred? (Loading Truck, Walking Down Stairs, etc.)	Where Did Accident Occur?

Specify Machine, Tool, Substance of Object Most Closely Connected With Accident	Were Others Injured in This Accident?

How Did Accident Happen? (State All Details; Use Additional Page if Needed)

If Validity of Claim is Doubted, State Reason:

Was Personal Protective Equipment Being Worn? Yes ◯ No ◯

If Yes, What Type? (Check One or More Items Below):

☐ Protective Clothing ☐ Seat Belts
☐ Foot Protection ☐ Hearing Protection
☐ Eye Protection ☐ Respirator
☐ Head Protection ☐ Back Support Belt

Other (explain)

If Another Person Not in County Employ Caused Accident, Give Name and Address:

Employee's Date of Hire	Employee's Work Hours	Employee's Scheduled Work Days	Was Employee on Overtime When Injury Occurred?

Witness Information: Name, Address, City, State, Zip	Area Code, Telephone Number of Each Witness

Additional Comments on Separate Sheet and Attach

Employment Category ◯ Regular, Full-Time ◯ Regular, Part-Time ◯ Temp ◯ Seasonal ◯ Volunteer

Supervisor Print Name	Sign Name	Phone No.	Date	Title

Employee Print Name	Sign Name	Office Direct Line #	Date	Title