**Injury Data Collection Form for Supervisors**

**Revised January 1, 2020**

**Instructions: Injured employee’s supervisor immediately completes form following work related injury and sends to agency staff responsible for reporting work related injury to third party administrator (CCMSI) via iCE web portal.**

|  |
| --- |
| **Employer Information** |
| **State Agency/Department:** |  |
| **Unit of State Agency/Department:** | **Unit Location:** |

|  |
| --- |
| **Claimant’s Personal Information** |
| **Claimant ID Number:****Type: □ Social Security Number □ Permanent Resident ID □ Employer Visa ID □ Federal ID** |
| **Last Name:** | **First Name:** | **Middle Name:** |
| **Street Address:** |  |
| **City:** |  | **State:** | **Zip Code:** | **County:** |
| **Work Phone:** | **Work Email:** | **Occupation:** |
| **Home Phone:** | **Cell Phone:** | **Personal Email:** |
| **Date of Birth:** | **Marital Status:** | **Gender:** |

|  |
| --- |
| **Incident Information** |
| **Date of Injury:** | **Time of Injury:** | **Date Injury Reported to Supervisor:** |
| **Describe fully how injury occurred and what employee was doing at the time of the injury:** |
| **What part and side of the body was injured?** |
| **Client assault: □ Yes □ No** | **Client Caused: □ Yes □ No** | **Salary Continuation eligible employee: □ Yes □ No** |
| **Time employee started work the day of the injury:** | **Did injury occur on employer’s premises? □ Yes □ No** |
| **Did employee return to work? □ Yes □ No** | **Date and time employee returned to work?** |
| **Where did injured employee go for medical treatment (Facility name, address, phone number)?**  |
| **Did injury require hospitalization? □ Yes □ No** | **Did injury require ER visit? □ Yes □ No** |

|  |
| --- |
| **Form Completed By:** |
| **Supervisor Name:** | **Supervisor Phone:**  | **Supervisor Email:** |