

**HENRICO
COUNTY GOVERNMENT AND PUBLIC SCHOOLS**

Worker's Compensation Supervisor's Investigation Report

PART I. EMPLOYEE INFORMATION		
DEPARTMENT OR SCHOOL	DEPARTMENT OR SCHOOL SECTION	DATE OF REPORT
Name of Injured:		
Last	First	Middle Initial
PART II. INJURY INFORMATION		
DATE OF INJURY	TO WHOM WAS THE INJURY REPORTED:	DATE INJURY REPORTED:
TIME OF INJURY:		TIME INJURY REPORTED:
Where did the injury occur? (Be specific, give exact location):		
PART III. SUPERVISOR'S INFORMATION		
Do you agree with the employee's version of how the injury occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, fully describe your version: (attach a separate sheet if necessary)		
PART IV. CORRECTIVE ACTION. Describe in detail the action you will take to prevent future similar accidents.		
PART V. RETURN TO WORK		
Has employee Returned to work? If so date: _____		
Regular Duty <input type="checkbox"/> Yes _____(date) <input type="checkbox"/> No Light Duty <input type="checkbox"/> Yes _____(date) <input type="checkbox"/> No		
PART VI. SIGNATURE		
PRINTED NAME OF SUPERVISOR	SIGNATURE OF SUPERVISOR	DATE SUPERVISOR PHONE:

NOTE: COMPLETE THIS FORM AND FORWARD TO RISK MANAGEMENT WITHIN 48 HOURS

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OF THE REPORT OF INJURY