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: