SUPERVISOR'S INVESTIGATION REPORT
Send completed form to workplaceinjury@cscc.edu

Employer:_____
Employee Name:_____ **CID:**_____
Date of Injury:_____

Was an investigation completed concerning the circumstances of this injury? ☐ Yes ☐ No

Were there any witnesses to this injury? ☐ Yes ☐ No
If yes, witness statements should be attached.

Was the injury a result of horseplay? Under the influence of drugs, or purposely self-inflicted? If yes, please specify: ☐ Yes ☐ No

_____
_____
_____

Has there been any recent disciplinary action taken against this employee? ☐ Yes ☐ No
If yes, please describe (and attach any written documentation):

_____
_____

Has the employee missed any work previously due to similar industrial or non -industrial conditions? If so, when? ☐ Yes ☐ No
_____
What preventive action measures do you recommend?_____
_____
_____

Has the employee submitted medical documentation for the injury? ☐ Yes ☐ No
If so, please attach.

If known, please provide us with the name, address and telephone number of the attending physician:

_____
_____
_____
_____

Has the employee returned to work? ☐ Yes ☐ No
Last day worked_____ Returned to work_____

If not, what is the current estimated date of return?_____

With the information you have, would you recommend the claim be accepted? ☐ Yes ☐ No
If no, why?_____
_____

_____ _____ _____
Employer's signature Title Date

PLEASE ATTACH COMPLETED INCIDENT REPORTS, WITNESS STATEMENTS AND ANY ACCUMULATED MEDICAL BILLS AND INFORMATION. ADDITIONAL COMMENTS MAY BE NOTED ON THE REVERSE SIDE.

COLUMBUS STATE
COMMUNITY COLLEGE