



Injury Data Collection Form for Supervisors

Revised July 1, 2023

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 (CorVel) via CareMC web portal.

Employer Information	
State Agency/Department:	
Unit of State Agency/Department:	Unit Location:

Claimant’s Personal Information			
Claimant ID Number:			
Type:	<input type="checkbox"/> Social Security Number	<input type="checkbox"/> Permanent Resident ID	<input type="checkbox"/> Employer Visa ID <input type="checkbox"/> Federal ID
State of NC Employee ID Number:			
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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Client Caused: <input type="checkbox"/> Yes <input type="checkbox"/> No	Salary Continuation eligible employee: <input type="checkbox"/> Yes <input type="checkbox"/> No
Time employee started work the day of the injury:	Did injury occur on employer’s premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did employee return to work? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did injury require ER visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Form Completed By:		
Supervisor Name:	Supervisor Phone:	Supervisor Email: