



# 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: <input type="checkbox"/> Social Security Number <input type="checkbox"/> Permanent Resident ID <input type="checkbox"/> Employer Visa ID <input type="checkbox"/> 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: <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: |