City of San Antonio
Supervisor Report of Injury or Illness

EMPLOYEE/PERSON INJURED (TO BE COMPLETED BY SUPERVISOR BY THE END OF THE WORK SHIFT)

1. Name (Last, First, M.I.):
2 SAP No.:
3. Sex: ☐ F ☐ M
4. Social Security Number: xxx-xx-
5. Cell Phone No.: ( ) -
6. Date of Birth (mm/dd/yy):
7. Does the Employee Speak English? If No, Specify Language ☐ Yes ☐ No
8. Injured Person Employee of COSA: ☐ Yes ☐ No
9. Race: White ☐ Black ☐ Asian ☐
10. Ethnicity: Hispanic ☐ Native American ☐ Other ☐
11 Mailing Address Street or P. O. Box
City State Zip Code County
12. Marital Status: Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
13. Number of Dependent Children:
14. Spouse's Name:
15. Doctor Name:
16. Phone Number: ( ) -
17. Mailing Address Street or P. O. Box
18. City State Zip Code
19. Does the employee plan to seek medical treatment for this injury? ☐ Yes ☐ No
20. Has the employee had medical treatment for this injury? ☐ Yes ☐ No

21. Date of Injury (mm/dd/yy):
22. Time of Injury: : am ☐ pm ☐
23.Date Lost Time Began (mm/dd/yy):
24. Nature of Injury:
25. Part of Body Injured or Exposed:
26. How and Why Injury/Illness Occurred:(See back of form to continue)
27. Was employee doing his regular job? ☐ Yes ☐ No
28. Worksite Location of Injury (stairs, dock, etc.):
29. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site:
Street or P. O. Box County
City State Zip Code -
30. Cause of Injury:
☐ Auto ☐ Bite ☐ Caught in/between
☐ Communicable Exposure (HIV, TB, Hepatitis, etc.) ☐ Ergonomics
☐ Foreign Body (Burn, dust, spit, blood splatter, chemical, splinter, glass, foreign object, etc.)
☐ Illness ☐ Lifting (bending, pushing, pulling, etc.) ☐ Over Exertion Slip, Trip,
☐ Fall ☐ Struck by/ struck against
☐ Other _____
31. List of Witnesses:
32. Return to work date/or expected (mm/dd/yy):
33. Supervisor's Name Completing Report
34. Date Reported (mm/dd/yy):

SUPERVISOR'S CORRECTIVE ACTION

35. What factors contributed to the incident/injury? (List safety policies, protocol or practices not followed?) Continue on back of form
36. What action was taken to prevent similar accidents? Continue on back of form
37. Was the employee performing duties in accordance with department procedures? If not, provide brief description. Continue on back of form ☐ Yes ☐ No Was this a prior injury: ☐ Yes ☐ No
38. Supervisor Name: Supervisor Phone Number ( ) -

SAFETY COORDINATOR INVESTIGATION AND FINDINGS

39. Investigation, findings and corrective action:
40. Root Cause (Refer to Box 30)
41. ARB Final Decision Preventable ☐ Non-Preventable ☐
42. Signature of Safety Coordinator:
43. Date of ARB:

TO BE COMPLETED BY HUMAN RESOURCES SPECIALIST

44. Date of Hire (mm/dd/yy):
45. Was employee hired or recruited in Texas? Yes ☐ No ☐
46. Length of Service in Current Position Years Month
47. Length of Service in Occupation Years Month
48. Employee's Cost Center
49. Department Division
50. Employee Payroll Classification Code
51. Occupation of Injured Worker
52. Rate of Pay at this job $____Hourly $____Weekly
53. Full Work Week is: ____Hours ____Days
54. Last Paycheck was: $ for Hours or Days
56. Name of Person Submitting Report and Phone Number: ( ) -

SUPERVISOR TO SEND COPIES TO: DEPT. MGR. HRS SAFETY COORDINATOR

Submit Print Form

26. How and Why Injury/Illness Occurred.

35. What factors contributed to the incident/injury? (List safety policies, protocol or practices not followed)

36. What action was taken to prevent similar accidents?

37. Was the employee performing duties in accordance with department procedures? If not, provide brief description.