Print Form

CITY OF SAN ANTONIO

Supervisor Report of Injury or Illness

MUST be completed and submitted within 24 hours of the incident

☐ Initial ☐ Amended Report #: _____ (Photos: ☐ No ☐ Yes By: _____)

DEPART CODE# (Required)

FOR RISK MGMT USE ONLY

Prev ___ **Non-Prev** ___

EMPLOYEE/PERSON INJURED (TO BE COMPLETED BY SUPERVISOR)

1. Name (Last, First, M.I.):
2. SAP No.:
3. Sex: F ☐ M ☐
4. Social Security Number: XXX-XX-
5. Home 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 WY Zip Code - County
12. Marital Status: Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
13. Number of Dependent Children:
14. Spouse's Name:
15. Name of Clinic/Hospital:
16. Phone Number: ( ) -
17. Mailing Address Street or P. O. Box City State WY Zip Code -
18. Doctor's Name:
19. Phone Number: ( ) -
20. Doctor's Mailing Address (Street or P. O. Box)
City State WY Zip Code -
21. Date of Injury (m/d/y):
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:
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 WY Zip Code -
30. Cause of Injury (fall, tool, machine, etc.):
31. List Witnesses:
32. Return to work date/or expected (mm/dd/yy):
33. Supervisor's Name:
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?)
36. What action will you take or recommend for preventing similar accidents?
37. Preventable ☐ Non-Preventable ☐
38. Supervisor's Name: Supervisor's Phone Number: (210) -

39. Print Name and Title of Person Completing Report:
40. Name of Business: City of San Antonio
41. Department Mailing Address and Telephone Number of Person Completed Report: Telephone (210) -
City San Antonio State TX Zip Code
42. Business Location (if different from mailing address): 111 Soledad, Suite 1000
City San Antonio State TX Zip Code 78205
43. Signature of Supervisor Completing Report:
44. Date:

TO BE COMPLETED BY HUMAN RESOURCES SPECIALIST

45. Date of Hire (mm/dd/yy):
46. Was employee hired or recruited in Texas? YES ☐ NO ☐
47. Length of Service in Current Position Months __ Years __
48. Length of Service in Occupation Months __ Years __
49. Employee's Cost Center
50. Department / Division /
51. Employee Payroll Classification Code
52. Occupation of Injured Worker
53. Rate of Pay at this job $_____ Hourly $_____ Weekly
54. Full Work Week is: _____ Hours _____ Days
55 Last Paycheck was: $_____ for _____ Hours or _____ Days
56 Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐
57. Name of Person Submitting Report and Phone Number: (210) -

SUPERVISOR TO SEND COPIES TO: DEPT. MGR. HRS SAFETY COORDINATOR **Email:** RiskMgmt@sanantonio.gov

COSA

Instructions

This report is to be completed by the Immediate Supervisor, (except bottom portion: Human Resources Section) on all injuries/illnesses reported by a City employee or a non-City employee.

Immediate supervisors must conduct a thorough investigation of the circumstances that led to the injury/illness and/or accident.

This report must be completed and forwarded to the Department Human Resources Specialist within twenty-four (24) hours following the injury/illness and/or accident.

The information contained in this report will be used in preventing similar accidents. **Reports with incomplete information will be returned for completion.**

The Risk Management Division will, as required, conduct independent investigations of accidents.

BLOCK: 1 through 22 - Self-explanatory.

BLOCK: 23 – Date lost time began (enter data in month, day, year format. Example: 08/01/2009)

BLOCK: 24 -. NATURE OF INJURY OR ILLNESS: (Examples to choose from)

AMPUTATION	BRUISE	CUT	HUMAN BITE	SKIN RASH
ANIMAL BITE	BURN	FATALITY	INSECT BITE	SPRAIN
BREATHING DIFFICULTY	CHEMICAL EXPOSURE	FOREIGN BODY	PUNCTURE	STRAIN
BROKEN BONE	COLD INJURY	HEAT INJURY	SCRAPE	UNCONSCIOUS

OTHER (Explain)

BLOCK: 25 - PART OF BODY INJURED OR EXPOSED: (Examples to choose from) Right side, Left side, Multiple Injuries

ANKLE	ELBOW	FOOT	HIP	MOUTH	STOMACH	UPPER LEG
BACK	EYE	FOREARM	JAW	NECK	TEETH	WRIST
CHEST	FACE	HAND	KNEE	NOSE	TOES	
EAR	FINGERS	HEAD	LOWER LEG	SHOULDER	UPPER ARM	OTHER (Explain)

BLOCK: 26 - Describe in detail:

(1) The events leading up to the injury/illness.

(2) Why the accident/injury occurred.

BLOCK: 27 - Self-explanatory

BLOCK: 28 - State the exact work-site location of the injury; stairs, storage area, construction site, etc.

BLOCK: 29 - Self-explanatory

BLOCK: 30 - List object, substance, or exposure that directly inflicted injury, e.g., tool, machine, chemicals, etc.

BLOCK: 31 - Self-explanatory

BLOCK: 32, 34 - Enter date in month/day/year format Example: 01/25/2009

BLOCK: 35-44 - Self-explanatory

BLOCK: 45-57 – To be completed by Human Resources Department