CITY OF KENTON

SUPERVISOR'S INVESTIGATION REPORT

Employee Name: _____ **Date of Injury:** _____ **OSHA Log #**_____

OSHA 301 Info in Bold

Was the employee killed as a result of the accident? If yes, indicate date of death:_____

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? □ **Yes** □ **No**

If yes, please specify details on the back of this form or on another page.

Has there been any recent disciplinary action taken against this employee? □ **Yes** □ **No**

If so, please describe:

_____

_____

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

Was the employee treated in an emergency room or similar? □ **Yes** □ **No**

Was the employee hospitalized overnight as an in-patient? □ **Yes** □ **No**

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

Physician:_____

Facility:_____

_____

_____

_____

_____

Has the employee returned to work? □ **Yes** □ **No**

Last Day worked _____ Returned to work _____

Does the employee have restrictions to duty? □ **Yes** □ **No** Applicable dates:_____

Is the employee performing their full duties? □ **Yes** □ **No**

Was the employee given a prescription by the physician? □ **Yes** □ **No**

Employee Date of hire: _____

Have the conditions that caused the accident been controlled? □ **Yes** □ **No**

Describe action taken to prevent the accident in the future:_____

_____

With the information you have, would you recommend the claim be accepted? □ **Yes** □ **No**

If no, why? _____

Completed by:

_____ _____

Supervisor Signature/Title/Phone Date

_____ _____

Workers' Compensation Coordinator Signature Date

**Please attach completed incident reports, witness statements and any accumulated medical bills and information. Additional comments may be noted on the reverse side.