County of DuPage

Supervisor Statement of Injury / Illness

To be completed by the Supervisor immediately upon notification of a work-related injury / illness.

Fax completed form within 24 hours of incident to HR Dept. - Fax # 630-407-6301

1. **Injured Employee Name (Print) :** _____
2. **Injured Employee's Job Title:** _____
3. **Date & Time of Incident:** _____
4. **Location of Incident:** _____
5. **Description of Incident:**

6. **Object / Equipment / Substance Contributing to Accident:**

7. **Witnesses to Incident:**

8. **Do you concur with the employee's account of the injury / illness?** ☐ **Yes** ☐ **No**

Please explain:

9. **Was there a violation of policy or procedure that contributed to the injury?** ☐ **Yes** ☐ **No**

If yes, explain:

10. **What corrective action has been taken to prevent similar incidents?**

11. **Did employee decline medical attention?** ☐ **Yes** ☐ **No**

12. **Medical Treatment to Employee:**

Supervisor Name (Print): _____ **Date:** _____

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