Care Center

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:** ____

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6. **Resident / Object / Equipment / Substance Contributing to injury / illness:**

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7. **Witnesses to Incident:** ____

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

   If No Please explain on back of form:

9. **Was there a violation of policy or procedure that contributed to the injury?** ❑ **Yes** ❑ **No**
   9a. Consider if the Care plan was followed? ❑ **NA** ❑ **Yes** ❑ **No**
   9b. CNA Assignment Sheet correct? ❑ **NA** ❑ **Yes** ❑ **No**
   9c. Had employee received training on this task previously? ❑ **Yes** ❑ **No**
   9d. Do we have formal training on how to safely perform the task? ❑ **Yes** ❑ **No**
   9e. Do we have a written policy/procedure in how to safely perform the task? ❑ **Yes** ❑ **No**

Other prevention comments ?____

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10. **Did employee decline medical attention?** ❑ **Yes** ❑ **No**
11. **Medical Treatment to Employee:** ____

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Supervisor Name (Print): ____ **Date:** ______________________