

**AGRITRUST OF GEORGIA
SUPERVISOR'S REPORT**

Employer: _____

Supervisor/Title (Completing this form): _____

Date of Injury: _____

Name of Injured: _____

Home Address: _____ Phone: () _____
(Street) (City, State, Zip code)

Your Current Job Title: _____ Length of time in position: _____

Length of time with current employer: _____

Positions held (if different than above) _____

INJURY INFORMATION:

Nature of Injury, Part of Body affected: _____

Describe the Accident and how it occurred: _____

Cause of the Accident: _____

Witness(es): _____ Statement taken? (Y/N) _____

Any reason to question the accident, if so why? _____

Safety training provided to the injured? Yes _____ No _____

Corrective actions taken to prevent recurrence: _____

Name of Physician chosen from Panel _____

Did the physician excuse the injured from work if so how long? _____

Did the Physician give work restrictions? If so, what are they? _____

Was Modified work recommended? If so was work provided? _____

Please check the list below if completed:

- | | |
|----------------------------------|---|
| _____ First Report | _____ Statement of the Injured |
| _____ Witness Statement | _____ Designated Physician Form |
| _____ Physician Appt for Injured | _____ Job Analysis(if restrictions are given) |

Supervisor Signature

Date