Injury Data Collection Form for Supervisors
Revised January 1, 2020

Instructions: Injured employee's supervisor immediately completes form following work related injury and sends to agency staff responsible for reporting work related injury to third party administrator (CCMSI) via iCE web portal.

<table>
<thead>
<tr>
<th>Employer Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Agency/Department:</td>
</tr>
<tr>
<td>Unit of State Agency/Department:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claimant's Personal Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claimant ID Number:</td>
</tr>
<tr>
<td>Type: □ Social Security Number □ Permanent Resident ID □ Employer Visa ID □ Federal ID</td>
</tr>
<tr>
<td>Last Name:</td>
</tr>
<tr>
<td>Street Address:</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>Work Phone:</td>
</tr>
<tr>
<td>Home Phone:</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incident Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Injury:</td>
</tr>
<tr>
<td>Describe fully how injury occurred and what employee was doing at the time of the injury:</td>
</tr>
</tbody>
</table>

What part and side of the body was injured?

<table>
<thead>
<tr>
<th>Client assault: □ Yes □ No</th>
<th>Client Caused: □ Yes □ No</th>
<th>Salary Continuation eligible employee: □ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time employee started work the day of the injury:</td>
<td>Did injury occur on employer's premises? □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Did employee return to work? □ Yes □ No</td>
<td>Date and time employee returned to work?</td>
<td></td>
</tr>
<tr>
<td>Where did injured employee go for medical treatment (Facility name, address, phone number)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did injury require hospitalization? □ Yes □ No</td>
<td>Did injury require ER visit? □ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>

Form Completed By:

| Supervisor Name: | Supervisor Phone: | Supervisor Email: |