



Arizona Counties Insurance Pool

1905 W. Washington St., Suite 200 Phoenix, AZ 85009 • (602) 452-4535 • FAX (602) 452-4517

SUPERVISOR'S REPORT OF INJURY INSTRUCTIONS

INJURY – No Treatment Required

1. SUPERVISOR downloads and completes Supervisor Report of Injury Form.
(Do not have employee fill out.)
 2. EMPLOYEE signs report.
 3. SUPERVISOR emails report to riskmgmt@pinal.gov indicating that no treatment sought at this time. SUPERVISOR instructs employee to request a copy of the completed Report of Injury if medical treatment is later required.
 4. If EMPLOYEE decides to seek medical treatment, SUPERVISOR provides employee a copy of the completed Report of Injury and follows protocol in the section below, starting at # 4.
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INJURY – Treatment Required

1. SUPERVISOR downloads and completes Supervisor Report of Injury Form.
(Do not have employee fill out.)
2. EMPLOYEE signs report.
3. SUPERVISOR gives a copy of Report of Injury form to employee, keeps a copy, and emails the report to riskmgmt@pinal.gov without delay. *(Fatalities must be reported to OSHA by Risk within 8 hours. Hospitalizations, amputations, loss of eyes must be reported to OSHA by Risk within 24 hours.)*
4. SUPERVISOR provides Prescription form to employee.
5. SUPERVISOR directs employee to appropriate facility. If assistance is needed to determine medical care and best facility for the injury, contact **Triage Now at 1-833-691-9021**.
Emergency Room is only used a last resort, unless the situation is an emergency.
6. SUPERVISOR informs employee of the availability of light duty.
7. SUPERVISOR require work status slip after all medical appointments, and sends information to: ohn.sharedmailbox@pinal.gov

SUPERVISOR'S REPORT OF INDUSTRIAL INJURY		MODIFIED DUTY IS AVAILABLE		Risk Management Use Only	
COMPLETE AND E-MAIL THIS REPORT TO RISK MANAGEMENT WITHIN 24 HOURS OF ACCIDENT		Billing Address: Arizona Counties Insurance Pool 1905 W. Washington St., Suite 200 Phoenix, AZ 85009		OSHA Case #: _____ Work Comp #: _____	
FATALITIES MUST BE REPORTED WITHIN 4 HOURS					
LAST NAME		FIRST NAME		MI	
				SOCIAL SECURITY NUMBER	
				BIRTH DATE	
STREET ADDRESS (NUMBER & STREET)		CITY		STATE	
				ZIP	
				HOME TELEPHONE	
MAILING ADDRESS (NUMBER & STREET)		CITY		STATE	
				ZIP	
SEX		MARITAL STATUS			
MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>			
EMPLOYER'S NAME			DEPT		
ADDRESS (NUMBER & STREET)			CITY		STATE
					ZIP
			WORK TELEPHONE		
Date of Injury		Time of Injury		Date Employer Notified of Injury	
				Date Employee Left Work	
				Date Returned to Work	
Employee's Occupation (Job Title) When Injured					
Address or Location of Accident					
		City		County	
				State	
				Zip	
On Employer Premises?		Nature of Injury (Scratch, Cut, Bruise, etc.)		Fatal?	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Part of Body Injured	
Will Treatment Be Sought?		If Yes, Where?			
What was Employee Doing When Accident Occurred? (Loading Truck, Walking Down Stairs, etc.)			Where Did Accident Occur?		
Specify Machine, Tool, Substance of Object Most Closely Connected With Accident			Were Others Injured in This Accident?		
How Did Accident Happen? (State All Details; Use Additional Page if Needed)					
If Validity of Claim is Doubted, State Reason:					
Was Personal Protective Equipment Being Worn? Yes <input type="checkbox"/> No <input type="checkbox"/>					
If Yes, What Type? (Check One or More Items Below):					
<input type="checkbox"/> Protective Clothing		<input type="checkbox"/> Seat Belts		Other (explain)	
<input type="checkbox"/> Foot Protection		<input type="checkbox"/> Hearing Protection			
<input type="checkbox"/> Eye Protection		<input type="checkbox"/> Respirator			
<input type="checkbox"/> Head Protection		<input type="checkbox"/> Back Support Belt			
If Another Person Not in County Employ Caused Accident, Give Name and Address:					
Employee's Date of Hire		Employee's Work Hours		Employee's Scheduled Work Days	
				Was Employee on Overtime When Injury Occurred?	
Witness Information:		Name, Address, City, State, Zip		Area Code, Telephone Number of Each Witness	
Additional Comments on Separate Sheet and Attach					
Employment Category					
<input type="checkbox"/> Regular, Full-Time <input type="checkbox"/> Regular, Part-Time <input type="checkbox"/> Temp <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer					
Supervisor Print Name		Sign Name		Phone No.	
				Date	
				Title	
Employee Print Name		Sign Name		Office Direct Line #	
				Date	
				Title	