City of Melrose Injured at Work- SUPERVISOR'S REPORT

To be completed by the Supervisor (not the employee) after meeting with the employee.
Submit to Matt Travers HR Dept; fax: 781-979-4246 within 24 hours of Incident.

Employee Name		Date of Submission	
Department		Job Title	
Date of Injury		Time of Injury	
Date Reported		# Days Lost from Work	
Nature of Injury			
Location where occured			
List Any Witnesses			

Description of Accident	
Cause of Accident	
Actions Taken to Prevent Similar Accidents	
Has the employee completed the probationary period?	_____Yes _____No
Has the employee been disciplined recently?	_____Yes _____No
If so, describe:	
Has the employee complained about affected body part in the past?	_____Yes _____No
Additional facts that should be considered in evaluating the claim?	

Are all required forms submitted and complete?	____**Yes** ____**No**
Incident Report	____**Yes** ____**No**
Medical Authorization	____**Yes** ____**No**
Supervisor Review	____**Yes** ____**No**
Doctor's Report	____**Yes** ____**No**
Return to Work Note	____**Yes** ____**No**

☐ APPROVED ☐ DISAPPROVED

_____ _____

Dept Head/Supervisor Signature Date

Please digitally sign or print and sign

Dept. Head/ Supervisor's E-mail: _____ **Phone#**_____