CITY OF SAINT PAUL

SUPERVISOR'S SAFETY REPORT

INJURY OR AGGRAVATION

THIS FORM MUST BE COMPLETED by the supervisor for each work-related injury or aggravation within 24 hours.

	Was time lost from	work? ☐ Yes ☐ No
Date of Injury Was site of injury visited? □ Yes	Was time lost from	work? ☐ Yes ☐ No
Was site of injury visited? ☐ Yes		
		sit
	occurrence?	
Was any corrective action taken?	□ No □ YesDescribe	
Did another person, tools, or equipme	nt contribute to this injury?	□ No □ YesIdentify and describe how
Was safety equipment available?	□ No □ Yes	☐ Does not apply
Was safety equipment in use?		
		working?
		time
employee's return-to-work. Find out Discuss other pertinent issues and q follow-up calls should take place every	nte? not in jeopardy because of ir t if light-duty will speed retur questions. week until return-to-work. nould be shared with departm	njury, and that you and co-workers are anxious for rn-to-work. nental Workers' Compensation liaison and the City's
f you or the employee have any quest	ions, please call the Workers	s' Compensation staff at (651) 266-6500.
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pervisor's Name		Supervisor's Phone