AGRITRUST OF GEORGIA
SUPERVISOR'S REPORT OF A CLAIM

Employer: _____

Supervisor/Title (Completing this form):_____

Date of Injury: _____

Name of Injured: _____

Home Address: _____ Phone: (____) _____

_____

Current Job Title: _____ Length of Time in Position: _____

Length of Time with 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? _____

Any Third Party Involvement? _____

Safety Training Provided to the Injured? Yes _____ No _____

Corrective Actions Taken to Prevent Recurrence: _____

Name of Physician Chosen from Panel _____

Drug Test Performed? If so, by whom? _____

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:

_____ WC-1First Report of Injury (Submit Immediately)

_____ Statement of the Injured _____ Witness Statement (Use this form)

_____ Drug Test Performed _____ Panel Physician Appointment Scheduled

_____ _____

Supervisor Signature Date