CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

Central File No. ______

SUPERVISOR'S REPORT OF INJURY OR ILLNESS

This form must be completed thoroughly by employee's supervisor within 24-hours after an accident

PART I - GENERAL INFORMATION

Employee Name	Title		Soc. Sec. No.
Address	City / State	Zip	Home Phone
Agency	Location		Work Phone

Job Description and/or Assigned Duties of Employee: (Be Specific)

Number of Years in current job title: ______

Previous job title: ______ Number of years previous title: ______

Activity at time of accident / incident: ______

Was said activity with the course and scope of employment or assigned duties ☐ Yes ☐ No		Date Accident / Incident	Hour: A.M. P.M.	Exact Location
Did you witness? ☐ Yes ☐ No	How was notice received? ☐ Written ☐ Oral	Date Received	Time Received	From Whom Notice Received

PART II – DETAILS OF ACCIDENT

Description of Accident / Incident:

Did a negligent third party cause or contribute to the accident? ☐ Yes ☐ No

If yes, explain and provide name, address, and phone number of negligent party (Use reverse side if necessary):

Description of Injury – Part(s) of Body Injured:

Name(s) of Witness(es) (if none, so state):

PART III – CAUSE OF ACCIDENT

Describe any unsafe acts or conditions which contribute to the accident / incident:

PART IV – CORRECTIVE ACTION TAKEN

Was the condition above corrected (how)?	Reported to higher authority (Name & Title)?
Name and Title of Supervisor	Did the incident result in any disciplinary action? ☐ Yes ☐ No

Signature of Supervisor ______ Supervisor Work Phone # ______ Report Date ______