



SUPERVISOR'S REPORT

[Form RM-05]

Rev. 06/2011

The statement of a(n):

- DIRECTOR
- MANAGER
- SUPERVISOR
- LEAD/ COORDINATOR
- Other:

EMPLOYEE'S INFO	EMPLOYEE'S NAME:		JOB TITLE:	SOCIAL SECURITY NO:
	HOME ADDRESS:			WORK PHONE:
	CITY, STATE and ZIP:			HOME PHONE:
	SEX: [] Male [] Female	DATE OF BIRTH:	EMPLOYMENT STATUS: [] Perm/Full Time [] Perm/ Part-time [] Substitute [] 9 mo [] 10 mo [] 11 mo [] 12 mo [] Other: _____	

LOCATION of INCIDENT (i.e. address, particular part of the building, etc. – include as much detail as possible)		
WHERE WERE YOU in RELATION to the INCIDENT WHEN it OCCURRED?		
DATE YOU WERE NOTIFIED:	TIME: AM / PM	WAS ANYONE ELSE INJURED in THIS INCIDENT?: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
NAME of OTHER INJURED PARTY: (if applicable)		TYPE of INURY/ILLNESS IF KNOWN:
Was there any PROPERTY DAMAGE ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does the employee need to seek medical treatment? Yes [] No []	Was employee referred to Company Nurse (if applicable.):

DESCRIBE HOW the INCIDENT OCCURRED (include complete names of parties involved and make sketches, if appropriate):	<input type="checkbox"/> SKETCH ON BACK
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DESCRIBE ANY APPARENT DAMAGE to PROPERTY (What was damaged and describe damage, i.e., : truck bumper, dented; car windshield, cracked)
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IN YOUR OPINION WHAT WERE the ROOT CAUSES of the INCIDENT:

Has employee missed any time from work? Yes [] No [] What was last day of work: ___/___/___ Has employee returned to work? Yes [] No [] When did they return to work: ___/___/___	Have you provided a claim form to the employee with a work comp packet? Yes [] No [] When was form provided: ___/___/___
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This form must be completed immediately upon knowledge of an accident and submitted to Risk Management at: (510) 644-8881 or e-mail to: riskmanagement@berkeley.net. FOR INFORMATION THAT WILL NOT FIT ON THIS FORM, PLEASE ATTACH ADDITIONAL SHEETS. Thank you.

SUPERVISOR'S NAME:	SUPERVISOR'S SIGNATURE:	DATE:
JOB TITLE:	WORK LOCATION:	WORK PHONE: