County of Henrico
Department of Finance, Risk Management Division

SUPERVISOR'S INVESTIGATION REPORT

Please complete this form along with the other necessary forms outlined in the "Worker's Compensation Reporting Flowchart" and send to the PMA within 48 hours (or next business day if occurrence is on weekend or holiday).

EMPLOYEE INFORMATION

Department: _____ **Division / School:** _____

Name of Employee: _____
Last *First* *Middle*

INCIDENT INFORMATION

Date of Injury: _____ **Time:** _____ ☐ **AM** ☐ **PM** **Was Care 24 called?** ☐ Yes ☐ No

Date Reported: _____ **Time:** _____ ☐ **AM** ☐ **PM** **To Whom?** _____

Was there a fatality? ☐ Yes ☐ No **Was there an amputation or loss of eye?** ☐ Yes ☐ No

Did the employee miss time from work? ☐ Yes ☐ No **If yes, list Dates:** _____

Has the employee returned to work? ☐ Yes ☐ No **Date Returned:** _____ ☐ **Light Duty** ☐ **Regular Duty**

Where did the injury take place? _____

Machine, tool, or object causing injury or illness: _____

Was there a Safety Violation? ☐ Yes ☐ No

If yes, describe: _____

Describe, in detail, how injury or illness occurred: _____

Recommended course of action to prevent similar accidents in the future: _____

SIGNATURE

_____ _____ _____
Supervisor's Signature **Printed Name** **Date**

Work Phone: _____ **Email:** _____

PLEASE SUBMIT THIS DOCUMENT AND RELATED BILLS TO PMA BY MAIL, FAX, OR EMAIL

Mail:
PMA Customer Service Center
PO Box 5231
Janesville, WI 53547-5231

Fax:
800-432-9762

Email:
ClaimMail@pmagroup.com
(Include the Employee's Name & Date of Injury in the Subject Line)