FREDERICK COUNTY PUBLIC SCHOOLS
Supervisor's Statement of Injury or Illness Form

To be completed by the injured employee's supervisor as soon as possible following the incident

******IMPORTANT PLEASE COMPLETE ALL SECTIONS******

FAX to 301-644-5122 or Email to: Workers.Comp@fcps.org

within 24 hours of incident

Injured Employee's Name:		School/Dept.:	
Employee ID#: Position:		Date of Accident:	
First Day of Lost Time:		Return to Work Date:	
When Did You First Learn of Any Claimed Injury or Accident:	Date:	Time:	AM ☐ PM ☐
Who Reported it to You?			
When Did You First Speak With the Employee About it?	Date:	Time:	AM ☐ PM ☐
Describe in detail what the employee reported to you (be as specific as possible about what was said):			
What areas of the body did the employee complain of (left hand, neck, back, etc.)? Be specific:			
Was personal protective equipment required at the time of the incident? (Yes or No) If "yes", was it utilized?			
Identify any potential Witnesses:			
Version of events as reported to you. Describe sequence of events or any objects or substances that could have contributed.			
Did the employee complete his or her shift? Yes ☐ No ☐			
Did the employee request/receive any medical treatment? Location? Explain:			
Your Name (Print):			
Your Position:			
Your Contact Information:	Work Phone:	Email Address:	
Supervisor's Signature:		Date:	