

# School District of Menomonee Falls

Attn: Human Resources  
Phone: 262-255-8449 or 8441  
Fax: 262-255-8461

## SUPERVISOR'S INVESTIGATION REPORT

Name of Injured Employee	Date:
Job Title and Department	
Date and Time of Injury	Type of Injury
Medical Facility	

What was the employee doing when injured? \_\_\_\_\_  
\_\_\_\_\_

Where did the accident happen? \_\_\_\_\_

Describe what happened: \_\_\_\_\_

What corrective steps will be done (or could be done) to prevent recurrence? \_\_\_\_\_  
\_\_\_\_\_

Was the employee working at designated job? Yes  No

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date



\_\_\_\_\_  
Human Resources Received by

\_\_\_\_\_  
Date Received

\_\_\_\_\_  
Dated Faxed to Comp. Carrier