

City of Somerville

SUPERVISOR'S FOLLOW-UP REPORT OF OCCUPATIONAL INJURY OR ILLNESS

This form MUST BE COMPLETED BY THE INJURED EMPLOYEE'S SUPERVISOR IN FULL and forwarded/faxed/emailed to Human Resources, Somerville City Hall, WITHIN 24 HOURS OF INJURY OR ACCIDENT. If you have any questions about the completion of this report or workers' compensation matters, call 617.625.6600 x3300 or fax 617.666.4426 workerscomp@somervillema.gov.

PLEASE PRINT OR TYPE.

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Injured Employee's Name (First, Middle, Last)		Date of Injury/Illness (mm/dd/yyyy)	
		1	1
Exact location of accident			
2,435,1654,167, 67, 686,167,17			
Has there been a follow-up investigation conducted into this report of accident?		Yes	No
If No, why not?			
If Yes, what corrective action has been taken to prevent a similar accident from	n happening? (e.g. equi	pment repair etc.)	
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Do you have any additional recommendations for preventing injuries of this type	pe?		
Name of person who conducted the investigation: (PRINT)			
Name of person who conducted the investigation. (FRINT)			
Supervisor's Name: (PRINT)	Title		
O construction of the construction	Date Report Complete	1.//11//	
Supervisor's Signature Date Repor		a (mm/aa/yyyy)	
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Additional Comments:			