Supervisor Report of Injury or Illness

Date of report (yyyy-mm-dd)

1. Reporting

Are you reporting this within three days of being notified of the injury or illness? ☐ Yes ☐ No		
Date you were notified	Time reported to you ☐ AM ☐ PM	Person who received notification at workplace
Has your employee been made aware of their right to file an application for benefits? ☐ Yes ☐ No		
Does your employee intend to file an application for benefits? ☐ Yes ☐ No ☐ Unknown		
Has your employee missed any time from work beyond the date of accident due to this injury/illness? ☐ Yes ☐ No		

2. Employee information

Employee's first name	Last name	Occupation

3. Injury or illness

How did the injury/illness happen?

☐ It was caused by a specific incident (Date: / Time: ☐ AM ☐ PM)

☐ It occurred over a period of time (date first symptoms were noticed:)

☐ It's a recurrence of previous workplace-related illness or injury (previous claim number:)

Body part(s) injured	Specify left, right or both if applicable ☐ Left ☐ Right ☐ Both	Workplace address/location where injury/accident occurred

Describe the accident in as much detail as possible, including what may have contributed to the injury or illness, OR attach your incident report.

Did the employee receive medical treatment? ☐ Yes ☐ No ☐ Unknown	If yes, name of health care provider/hospital/clinic: Date of visit:

4. Work function

Offering modified work as soon as possible supports worker recovery and is a legislative requirement for New Brunswick employers.

Did you offer modified work (change of duties/tasks, reduced hours, etc.)? ☐ Yes ☐ No If yes, when:	Has the employee returned to work? ☐ Yes ☐ No If yes, when: ☐ Full time ☐ Part time ☐ Full duties ☐ Modified duties

Please return completed form to your Education Centre Human Resources Officer via Email