Supervisor's Report of Employee Injury (SREO)

*Submit this form for every work-related injury/illness/exposure (including BBF/BBP) within **48** hours of injury.
*Applicable to all employee, temps/contractors, residents, medical students, volunteers and physicians.
*Employees exposed to blood or body fluids (BBF/OPIM) must also consult with Occupational Health Services.
***Required fields**

Injured/Ill/Exposed Employee Information:

☐ One Employee Affected ☐ Two or More Employees

Last Name: *	First Name: *	Middle Initial:
Employee ID #:		
Employee's Home Cost Center Name: *		

Select this option if mass exposure or illness involving two or more employees. Enter information for one employee per form submitted.

Injury/ Illness/ Exposure Details:

Date of Injury/ Illness/ Exposure: *

Supervisor's Investigation Report: Who? What? When? Where? How? Why? *

Example:
Mr. John Doe, a full-time employee in the Transportation Department at SHC, suffered an injury on January 8, 2011 at 7:15pm. Mr. Doe was walking down the hallway on the 2nd floor, East Corridor outside Echo lab when he fractured his wrist after slipping on a wet substance on the floor. He stated that he saw the substance but felt confident he could step over it. Apparently the spilled occurred 10 minutes prior to his injury but housekeeping had not arrived yet and no barriers were in place. Mr. Doe was taken to the emergency department, where he received treatment and the wrist was stabilized and cast. He was sent home and will be out of work for the next six weeks.

Corrective Action Taken/Intended:*

Example:
Corrective Action will be to clean up spills immediately, evaluate slip resistant footwear program, conduct counseling and awareness training for all staff exposed to hazard, and request slip resistant floor surface evaluation.

Witness to Occurrence:	
Name:	Name:
Department:	Department:
Phone:	Phone:

Supervisor / Manager Information:	
Name:*	
Title:*	
Telephone Number:*	
Email:*	Date Form Completed:*

By signing this form, I acknowledge I am the stated employee's supervisor and all the information I have provided above is accurate to the best of my knowledge.

Supervisor's Signature: *	Date:*

Submit this completed form to Kate Dohn at kdohn@stanfordmed.org or fax to Kate Dohn (650) 736-2495. This form must be submitted within **48 hours** of employee being seen by Occupational Health Services.

If you have any questions or concerns regarding this form or need to make a change, please e-mail Kate Dohn in Risk Management at kdohn@stanfordmed.org. Please reference employee name and date of injury occurred.