STATE OF MISSOURI
OFFICE OF ADMINISTRATION
RISK MANAGEMENT SECTION

WORKERS' COMPENSATION INVESTIGATION REPORT - SUPERVISOR STATEMENT

CENTRAL ACCIDENT REPORTING OFFICE (CARO)
P.O. BOX 809
JEFFERSON CITY, MO 65102
573/751-2837 FAX: 573/751-5262

TO	WCU CASE NUMBER

We understand you are the supervisor of ______________________________ .
This employee has reportedly suffered an injury which may be compensable under the Missouri Workers' Compensation Law. As the supervisor, you have the responsibility of reporting employee injuries. Before a decision can be made on accepting the injury, this form must be filled out by you. It is **very important** you complete in detail and do not leave any blanks. Return this form immediately to the Central Accident Reporting Office (CARO). Questions, call 573-751-2837.

1. WHEN WERE YOU INFORMED OR MADE AWARE THAT THIS EMPLOYEE SUFFERED AN INJURY? PLEASE GIVE DATE AND TIME.

2. HOW WERE YOU INFORMED OR MADE AWARE THAT THIS EMPLOYEE HAD SUFFERED AN INJURY?

3. WHAT WERE YOU TOLD REGARDING THIS INJURY?

4. WHAT PART OF THE EMPLOYEE'S BODY WAS REPORTED INJURED TO YOU?

5. WHEN WAS THE EMPLOYEE INJURED? GIVE DATE AND TIME REPORTED TO YOU.

6. WHERE DID YOU REFER EMPLOYEE FOR MEDICAL TREATMENT?

7. EXPLAIN ANY DELAYS IN REPORTING THE INJURY OR SEEKING MEDICAL TREATMENT.

8. LIST WITNESSES

9. ADDITIONAL INFORMATION THAT MAY BE BENEFICIAL IN THE REVIEW OF THIS CLAIM.

I HAVE PREPARED AND READ THE ABOVE AND DECLARE IT TO BE TRUE.

SIGNED	DATE

MAILED CARO	RECEIVED CARO