

Bear, Smokey
555-55-5555
Write last name, first name and social security # at the top

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and zip code)

USDA Forest Service ASC-HRM
3900 Masthead NE, Annex WC
Albuquerque, NM 87109

OWCP Agency Code
FS WC completes

OSHA Site Code
FS WC completes

ZIP Code

18. Employee's duty station (Street address and ZIP code)

Employee's duty station location

19. Employee's retirement coverage

CSRS FERS Other, (identify)

20. Regular work hours From 0900 a.m. To 1800 p.m.

21. Regular work schedule Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

22. Date of Injury Mo. Day Yr. 02/10/2009

23. Date notice received Mo. Day Yr. 2/11/2009

24. Date stopped work Mo. Day Yr. 2/10/2009 Time: 1000 p.m.

25. Date pay stopped Mo. Day Yr. N/A

26. Date 45 day period began Mo. Day Yr. 2/11/2009

27. Date returned to work Mo. Day Yr. 2/20/2009 Time: 0900 p.m.

28. Was employee injured in performance of duty? Yes No (If "No," explain)

Supervisor should contact FS WC with any concerns about claim

Leave blank if employee hasn't returned to work. If no time lost, enter date of injury or enter date employee returned to work

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? Yes (If "Yes," explain) No

If yes, statement may be addressed in a separate sheet of paper

30. Was injury caused by third party? Yes No (If "No," go to item 32.)

31. Name and address of third party (Include city, state, and ZIP code)

Complete this section for third party involvement

32. Name and address of physician first providing medical care (Include city, state, ZIP code)

Complete treating physician information if available

33. First date medical care received Mo. Day Yr. 02/10/2009

34. Do medical reports show employee is disabled for work? Yes No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? Yes No (If "No," explain)

If no, statement may be addressed in a separated sheet of paper

36. If the employing agency controverts continuation of pay, state the reason in detail.

Statement may be addressed in a separated sheet of paper

37. Pay rate when employee stopped work \$ Per

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature: Gifford Pinchot Date

Supervisor's title Office phone Provide a phone number you can be reached at

39. Filing instructions

No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)

No lost time, medical expense incurred or expected: forward this form to OWCP

Lost time covered by leave, LWOP, or COP: forward this form to OWCP

First Aid Injury

Please check the applicable box