WORKERS COMPENSATION SUPERVISORS REPORT AND ACCIDENT INVESTIGATION FORM

Complete within 24 hours after accident or incident.

Name of Employee:

Date of Accident/Incident:

Time of Accident/Incident: ◯ A. M. ◯ P. M.

Employee's Occupation:

School or Location Name Where Injury Occurred:

Date Reported:

Years Employed:

Time Employee Started Working: ◯ A. M. ◯ P. M.

Was there a delay of 24 hours or more in reporting? ◯ Yes ◯ No

If yes, explain.

Time Injury Occurred:

◯ During Break Period ◯ Working OT

◯ Entering/Leaving ◯ While Performing Duties

◯ Other (Explain) ______________________________

Did employee lose time from work? ◯ Yes ◯ No

Hours lost on date of accident: ________________

Has employee returned to work? ◯ Yes ◯ No

Years in Occupation at Time of Accident:

◯ 0 - 5 months ◯ 3 to 5 years

◯ 6 months to 1 year ◯ More than 5 years

◯ 1 to 3 years

If medical treatment was received, please list the clinic/doctor visited and date of visit.

Clinic/Hospital: ______________________________

Address: ______________________________

Phone Number: ______________________________

Name of treating health care provider: ______________________________

Date of initial visit: ________________

Was this an emergency room visit? ◯ Yes ◯ No

Was there an overnight stay? ◯ Yes ◯ No

Describe the nature of the injury (strain, laceration, bruising, scratch, fracture and the body part affected (left arm, right shin, etc.)

Why did the unsafe condition exist? What did the employee or another person do incorrectly?

Why did the unsafe act occur?

What has been done to correct the conditions that caused the injury?

Additional information that you feel is important.

Form Completed by:

Signature:

Date:

Describe the events and conditions that contributed to the accident.

- ◯ Lifting and Handling
  - ◯ Item was too heavy
  - ◯ Item was carried too far
  - ◯ Mechanical aids not available
  - ◯ Item was of an awkward size
  - ◯ Other ______________________
- ◯ Motor Vehicle
  - ◯ Hit by another vehicle
  - ◯ Road hazard
  - ◯ Other ______________________
- ◯ Indoor Slip
  - ◯ Liquid spilled on floor
  - ◯ Footwear
  - ◯ Damaged carpet or tile
  - ◯ Lighting
  - ◯ File drawer left open
  - ◯ Items left on floor
  - ◯ Slippery floor treatment (wax)
  - ◯ Other (horseplay)
- ◯ Outdoor Slip
  - ◯ Uneven walkway surface
  - ◯ Ice or snow
  - ◯ Footwear
  - ◯ Lighting
  - ◯ Other ______________________
- ◯ Students
  - ◯ Restraining
  - ◯ Items being thrown
  - ◯ Biting/Hitting/Kicking
  - ◯ Other ______________________
- ◯ Other
  - ◯ Poor housekeeping
  - ◯ PPE not worn or provided
  - ◯ Improper or defective equipment (broken stool, chair, ladder)
  - ◯ Other ______________________

Sketch of Accident Scene (Most likely used with a motor vehicle accident.)

Were the unsafe acts/conditions reported prior to the incident?

Have there been similar incidents prior to this one?

What changes do you suggest to prevent this accident/incident from happening again?

- ◯ Stop this activity
- ◯ Guard the hazard
- ◯ Train the employee (s)
- ◯ Train the supervisor (s)
- ◯ Redesign the task steps
- ◯ Redesign work station
- ◯ Write a new policy/rule
- ◯ Enforce existing policy
- ◯ Routinely inspect for the hazard
- ◯ Personal Protective Equipment
- ◯ IEP/Team Meeting
- ◯ Other ________________

What corrective or preventative actions have been or should be taken to reduce the risk of a similar incident in the future?

Action	Responsible Party	Time Frame	Action Completed?
			◯Yes ◯ No
			◯Yes ◯No
			◯Yes ◯ No
			◯Yes ◯No
			◯ Yes ◯No

Department Safety Team Members:

________________________________ ________________________________

________________________________ ________________________________

Additional Notes (Attach additional documentation if necesssary):