

# SUPERVISOR'S REPORT OF ACCIDENT

## SCHOOL DISTRICT INFORMATION

NAME OF SCHOOL DISTRICT \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

DIVISION \_\_\_\_\_

LOCATION \_\_\_\_\_

PHONE \_\_\_\_\_

## EMPLOYEE INFORMATION

EMPLOYEE'S NAME: FIRST, MIDDLE, LAST \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_

MALE  FEMALE

DATE OF BIRTH \_\_\_\_\_

GENDER \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

OCCUPATION \_\_\_\_\_

DEPARTMENT \_\_\_\_\_

## ACCIDENT INFORMATION

DATE OF ACCIDENT \_\_\_\_\_

TIME OF ACCIDENT \_\_\_\_\_

A.M.  P.M.

REGULAR WORK? \_\_\_\_\_

Describe injury: \_\_\_\_\_

Body part injured: \_\_\_\_\_

Witness info: \_\_\_\_\_

Fatality?  YES  NO

How did the accident happen? \_\_\_\_\_

Employment date: \_\_\_\_\_

How long on this job? \_\_\_\_\_

Detail all machine or equipment involved: \_\_\_\_\_

Specify activity employee was engaged in when accident occurred: \_\_\_\_\_

What safety words or safety equipment was in place? \_\_\_\_\_

What should be done to prevent repetition? \_\_\_\_\_

Has it been done?  YES  NO If not, give reason: \_\_\_\_\_

NAME OF PHYSICIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME OF HOSPITAL \_\_\_\_\_

ADDRESS \_\_\_\_\_

## SIGNATURES

SUPERVISOR'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

REVIEWED BY \_\_\_\_\_

DATE \_\_\_\_\_