

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 _____

DATE OF BIRTH _____ GENDER MALE FEMALE 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 _____