SUPERVISOR ACCIDENT REPORT FORM

DISTRICT: __________________________ SCHOOL: ______________________________________________________

NAME OF INJURED PERSON: _________________________________________________________________________

ACCIDENT DATE: ______ ACCIDENT TIME: __________ DATE REPORTED _______________________

EMPLOYEE [ ] STUDENT [ ] VISITOR [ ]

If injured person is an employee please provide the following:

JOB POSITION: __________________________ DATE OF HIRE: ________________________________

HOURS USUALLY WORKED PER DAY: __________ PER WEEK: ______________________________

SPECIFIC BODY PART INJURED: ______________________________________________________________________

TYPE OF INJURY (Puncture, sprain, contusion, etc.): _______________________________________________

WAS FIRST-AID REQUIRED? YES [ ] NO [ ] LOST TIME INVOLVED? YES [ ] NO [ ]

PROPERTY DAMAGE INVOLVED? YES [ ] NO [ ] DESCRIBE:
________________________________________________________________________________________

HOW DID ACCIDENT OCCUR? (Object, activity or substance involved?): _______________________________
________________________________________________________________________________________

WAS PERSONAL PROTECTIVE EQUIPMENT NEEDED? YES [ ] NO [ ] USED? YES [ ] NO [ ]

WHAT UNSAFE ACTS CONTRIBUTED TO THE ACCIDENT?
________________________________________________________________________________________

CORRECTIVE ACTION TO BE TAKEN FOR UNSAFE ACT: (e.g. training, discipline) __________________
________________________________________________________________________________________

WHAT UNSAFE CONDITIONS CONTRIBUTED TO THE ACCIDENT? ____________________________________
________________________________________________________________________________________

HAD THIS CONDITION BEEN REPORTED PREVIOUSLY? YES [ ] NO [ ]

TO WHOM? __________________________________________________________________________________

CORRECTIVE ACTION TO BE TAKEN FOR UNSAFE CONDITION: _____________________________________
________________________________________________________________________________________

WAS ACCIDENT CAUSED BY SOMEONE NOT ON EMPLOYER’S PAYROLL? YES [ ] NO [ ]

IF SO, WHOM? ______________________________________________________________________________

WITNESSES? YES [ ] NO [ ] NAMES: _____________________________________________________________

WAS THE ACCIDENT CAPTURED ON A VIDEO SURVEILLANCE SYSTEM? YES [ ] NO [ ]

If yes, please forward a copy of the video to ESD 105 Workers’ Compensation

WITNESS STATEMENT(S) RECEIVED? ________________________________

SUPERVISOR SIGNATURE: ____________________________________ DATE: ____________________________

*To be completed within 24 hours and sent to District Contact