

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