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 <u>NOT</u> 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**

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