REPORT OF ACCIDENT/INCIDENT/INJURY

*This is **NOT** a Workers Compensation claim form, nor does it replace a notice of claim or petition for Workers Compensation benefits.*

This form is to be completed for ALL accidents, injuries and incidents (an incident is an "almost happened").

Employee name: ____________________________ School/department:________________________

Job Position_________________ Hrs worked/day ____ hrs/week____ Supervisor ________________

Please check the appropriate box:

❑ Accident/Injury ❑ Accident/No Injury ❑ Incident/Near Miss ❑ Unsafe Condition

Witnesses or other people involved: ____

____

Please identify others by name and involvement, such as John Jones, witness or Jane Jones, other driver.

Date and Time of Accident/Incident/Injury: Date: __________________ Time: ______________ a.m./p.m.

Reported To: ____
Name

Date Reported: __________________________________ Time Reported: ______________ a.m./p.m.

Exact location of accident/incident/unsafe condition: ______________________________________

____

Last Day Worked: __________________ Date you expect to return to work: _________________

Were you injured? **( ) Yes ( ) No** If yes, describe your specific injury, including all body parts affected, specify **Right** or **Left** ____

____

Do you require First Aid? **( ) Yes ( ) No** Do you require Doctor's treatment? **( ) Yes ( ) No**

Describe any results of the incident you think are important, including injury to others, property damage, etc. (use additional sheets if necessary) ____

____

____

Explain why the accident/incident/unsafe condition happened (use additional sheets if necessary) ____________

____

____

Explain, as best you can, why the causes were present (use additional sheets if necessary) ____________________
____
____
____

How do you recommend that recurrence or similar incidents be prevented? ________________________
____

EMPLOYEE SIGNATURE: ____________________________________ DATE: __________________

To be completed by Supervisor Only:

Do you concur with the employee's account of the accident/incident/unsafe condition? **( ) Yes ( ) No**

If No, what additional facts do you have to add? ____
____
____

Facts resulting from investigation: ____
____
____

Was Personal Protective Equipment needed? **( ) Yes ( ) No** Used? **( ) Yes ( ) No**

What unsafe acts/conditions contributed to the accident? _______________________________________
____
____

Corrective Action:	Responsible Person	Date to be Completed

Signature of Supervisor ________________________________***Date*** ______________________

To be Completed Within 24 Hours and Routed to Human Resources.