

**KANSAS ASSOCIATION OF SCHOOL BOARDS
SUPERVISOR'S ACCIDENT INVESTIGATION REPORT**

This report is to be filled out as soon as the accident is reported by the injured person. This form and the "EMPLOYER'S REPORT OF ACCIDENT" form must be sent to the Safety Coordinator ASAP and forwarded to the Gallagher Woodsmall claims department.

Name of person injured: _____ Age: _____

Department: _____ Employment status: Full-time Part-time Volunteer

Job Title: _____ Hours into shift: _____ How long employed: _____

Date of accident/injury: _____ Time of accident/injury: _____ a.m./p.m. Date reported: _____

Type of injury/illness: _____ Body part affected: _____

Exact location of accident: _____

Specific activity when accident occurred: _____ Was accident site reviewed by supervisor? Yes No

Did supervisor interview injured person? Yes No Did supervisor interview eyewitnesses? Yes No

Exactly how did accident occur? Describe persons, action, equipment, conditions, etc. _____

Was employee using required safety equipment, materials, or chemicals? Yes No N/A

What could have been utilized to prevent this accident? _____ Is it available? Yes No

Briefly explain how each of the areas listed below can be improved to help prevent similar accidents.

Training: _____

Communications: _____

Policies/procedures: _____

Inspections: _____

Supervisor's Accident Report: (continued)

Report of injured employee attached? Yes No

Reports of eyewitnesses attached? Yes No

Was first aid administered on the scene? Yes No

Was employee taken to the hospital/clinic? Yes No If so, by whom? _____

Who authorized medical treatment? _____

What immediate action has been taken to prevent occurrence of a similar accident? _____

Upon completion of this investigation, sign and turn in to the person in your facility who is responsible for filing workers' compensation claims.

Supervisor signature

Date

ROUTING

Department Head (if different than supervisor) comments: _____

Department Head signature

Date

Safety Committee Chairperson comments: _____

Safety Committee Chairperson signature

Date

Superintendent comments: _____

Superintendent signature

Date

REPORT BY INJURED EMPLOYEE

Employer: _____

Your Name: _____

Your Home Address: _____

Your Home Phone Number: _____ Age: _____

Social Security Number: _____

Date of Accident: _____ Time of Accident: _____

In your own words, please describe what happened: _____

What physical problems do you relate to this injury? _____

Did you report this injury to your supervisor? _____ If not, why not? _____

Date Reported: _____ Supervisor's Name: _____

Were you working at your regular job at the time of the injury? _____ If not, please explain:

Were there any witnesses? _____ If yes, who? _____

Any additional comments: _____

