Kansas Association of School Boards
Supervisor's Accident Investigation Report

This report is to be completed by the injured person's supervisor before the end of the shift during which the accident or illness occurred.

NAME OF INJURED PERSON:____

AGE: ____________EMPLOYMENT STATUS FULL-TIME❐ PART-TIME❐ VOLUNTEER❐

DATE OF ACCIDENT:__________________DAY OF ACCIDENT:_________________TIME:_______________A.M. / P.M.

DEPARTMENT:___________________________________OCCUPATION:______________________________

HOURS INTO SHIFT WHEN OCCURRED:________________HOW LONG EMPLOYED?___________________________

EXACT LOCATION OF ACCIDENT:____

WAS ACCIDENT SITE REVIEWED BY SUPERVISOR? Yes ❐ No ❐

DID SUPERVISOR INTERVIEW INJURED PERSON? Yes ❐ No ❐

DID SUPERVISOR INTERVIEW WITNESSES? Yes ❐ No ❐

EXACTLY HOW DID ACCIDENT OCCUR? DESCRIBE PERSONS, ACTION, EQUIPMENT, CONDITIONS, ETC.:

____

____

____

WAS EMPLOYEE WEARING/USING REQUIRED SAFETY EQUIPMENT? Yes ❐ No ❐ N/A ❐

WHAT EQUIPMENT COULD HAVE BEEN UTILIZED TO PREVENT THIS ACCIDENT?

____

____

IS THIS EQUIPMENT AVAILABLE FOR EMPLOYEE USE? Yes ❐ No ❐

FOR EACH OF THE FOLLOWING FACTORS, INDICATE WHAT COULD BE IMPROVED TO PREVENT THIS ACCIDENT:

TRAINING

____

____

____

COMMUNICATIONS

____

____

____

POLICIES/PROCEDURES

____

____

____

INSPECTIONS/OBSERVATIONS

____

____

____

WHAT IMMEDIATE ACTION HAS BEEN TAKEN TO PREVENT THE RECURRENCE OF A SIMILAR ACCIDENT?

____

REPORT BY INJURED EMPLOYEE ATTACHED? Yes ❐ No ❐

REPORTS OF EYEWITNESSES ATTACHED? Yes ❐ No ❐

WAS FIRST AID ADMINISTERED ON THE SCENE? Yes ❐ No ❐

WHO AUTHORIZED MEDICAL TREATMENT?____

SUPERVISOR SIGNATURE:_________________________________ DATE:_______________

****

TO BE ROUTED TO:

****

TO BE FILLED OUT BY THE DEPARTMENT DIRECTOR

COMMENTS:____

____

____

SIGNATURE_____________________________________ DATE_______________

TO BE COMPLETED BY SAFETY COORDINATOR

COMMENTS:____

____

____

SIGNATURE_____________________________________ DATE_______________

TO BE COMPLETED BY SUPERINTENDENT

COMMENTS:____

____

____

SIGNATURE_____________________________________ DATE_______________

REPORT BY INJURED EMPLOYEE

Employer:____

Your Name:____

Your Home Address:____________________________________

Your Home Phone Number:________________________________

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?____________________________

Did you go to a hospital/clinic? Yes__________No_________

Address of hospital/clinic:____________________________________

Name of treating physician:___________________________________

Any additional comments:____________________________________

Date

Signature

REPORT BY EYEWITNESS

Name:____

Name of Injured Employee:____

Name of Witness:____

Address:____

Telephone Number:____

Date of Incident:____

In your own words, describe what you saw happen:

____

____

____

Did anyone else see the accident? ❒ Yes ❒ No

If yes, please list their name(s)?____

____

Other comments:____

____

Signature of Eyewitness:____