

**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: _____