

San Juan School District #149
Employee Incident/Accident Report

Describe the accident in sufficient detail to show the conditions that existed at the time of the accident. Any unsafe acts or conditions should be noted.

***** Please FAX immediately to the District Office, 378-6276 *****

All incidents/accidents must be reported to the staff supervisor within 24 hours from the date of incident. Please note that any accident or incident that causes in-patient hospitalization of one or more employees must be reported to L&I within 8 hours. Please note that L&I claims are processed by your medical provider. **Report all work-related injuries or accidents to your medical provider to begin the process for Labor and Industries (L&I) claims.**

Employee to complete this portion of the report

Employee Name: _____ Date of Incident/Injury: _____
Location: _____ Date of Report: _____
Position Description: _____ Time of Injury: _____ (a.m./p.m.)
Who Incident Was Reported to: _____ Time Shift Began: _____ (a.m./p.m.)
Incident/Accident Location: _____
Describe in Detail the nature of incident/accident: _____

Description of Injury: (include body part(s) affected and nature of injury: _____

First Aid provided (Internal): Yes No Medical Treatment Needed: Yes No

Date of Treatment and name of Medical Facility: _____

If treated, did you request the medical provider file an L&I Claim? Yes No

Suggestions/Comments on ways this incident/accident may have been prevented: _____

Witnesses and Contact Numbers: _____

Signature of Injured Worker

Supervisor Signature

Supervisor to complete this portion of the report

Employee Information:

Address & Phone: _____

Date of Birth: _____ Date of Hire: _____ Work Schedule/Hours: _____ Wages: _____

Describe in detail your understanding of the incident claimed: _____

Specific comments, recommendations or action necessary to prevent reoccurrence of this incident (i.e. use of PPE's, personal factors, mechanical defects): Was an unsafe act committed? If so, give details. _____

Do you question the validity of the incident as described by the employee? If yes, please specify: _____

Supervisor Name: _____ Phone: _____ Signature: _____

Safety Committee Recommendations

1. _____
2. _____
3. _____

Witnesses

Witness Name _____ Address _____ Phone _____

Witness Name _____ Address _____ Phone _____

Witness Name _____ Address _____ Phone _____

Supervision

Supervising staff when Accident / Incident occurred: Name: _____

Present at scene? (yes/no): _____ Title: _____

Additional notes: _____

Action / Response

Immediate action taken: _____

First Aid given by: _____

Describe Aid: _____

Check action: Sent to office ___ Sent home ___ 911 called ___ Sent to Dr. / hospital ___

Notification

Check family member/guardian notified: Mother ___ Father ___ Guardian ___

Other (include description of relationship) _____

Contact phone number: _____ Responded to scene? (yes/no) _____

When notified? _____ By whom? _____

Insurance: _____

Person preparing report: _____ Title: _____

Signature: _____ Date: _____

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