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 (Supervisor completes page 2)

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: _____

_____

_____

(Please list witnesses and contact numbers on back of form)

_____ _____

Signature of Injured Worker Supervisor Signature

Supervisor to complete second page of the report

Employee's name and contact information: _____

Describe in detail your understanding of the incident claimed: _____

_____

_____

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

_____

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._____

_____

_____

Supervisor Name: _____ Phone: _____Signature: _____

Witnesses: Witness Name _____ Phone _____

Witness Name _____ 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 building office ____ Sent home ____ 911 called ____ Sent to Dr. / hospital ____

Notification

Family member/guardian notified (yes/no, include relationship)_____

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

When notified? _____ By whom? _____

Insurance: _____

Person preparing report: _____ Title: _____

Signature: _____ Date: _____

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Revised 3/15/2022