SNAKE RIVER SCHOOL DISTRICT #52
EMPLOYEE AND SUPERVISOR ACCIDENT REPORT

5460F2
(Worker's Comp)

This form must be completed by the injured employee and given to his/her supervisor or principal within 24 hours after an accident.

EMPLOYEE: Please complete

PART A: EMPLOYEE INFORMATION:

Name of injured employee_____ **Soc. Sec. #** _____

Address _____ **City** _____

Home Phone # _____**Marital Status** _____ **# of children under 18** _____

PART B: ACCIDENT INFORMATION:

Place of accident or injury _____ **Date of accident or injury:** _____

Time of accident or injury: _____**am/pm Date supervisor learned of accident** _____

Injury reported to (person) _____ **Did you finish your shift?** _____

If you missed work, give dates: _____

Have you returned to work? _____ **If yes, give date:** _____

What were you doing when accident occurred? (Example: Lifting desk, loading truck, walking down stairs)
BE SPECIFIC _____

_____

How did the accident happen? (Example: lost grip and desk landed on my foot) _____

_____

Describe the injury as exactly as possible (Example: Smashed 4 toes, right foot) _____

_____

What object, substance, tool, or machine was most closely connected with the accident? _____

_____

If mechanical apparatus or vehicle, what part of it? (Gears, pulley, blade, motor, etc.) _____

Was accident caused by failure of a machine or product? (if yes, explain) _____

Were mechanical guards or other safeguards provided? _____ **Were you using them?** _____

Did anyone witness the accident? If so, list the person(s) _____

If accident was caused by any person or business other than you, please identify: _____

_____

Did you see a doctor? _____ **Name and Address of doctor** _____

Indicate body part affected _____**left** _____**right. Was this part of the body injured before?** _____

If so, when and how? _____

Write brief description of the treatment given _____

Employee Signature _____ **Date:** _____

I understand that if I choose to go to a physician or facility other than the one assigned by the district, the State Insurance Fund may deny my claim and I will be responsible for those charges.

Employee Signature _____ **Date:** _____

TO BE COMPLETED BY SUPERVISOR <u>with Employee</u> during accident investigation.

Date accident was reported to you _____ **Time** _____ **am/pm**

Was employee on duty at the time of the accident? _____ **Performing normal duties:**_____

Did employee leave work? _____ **Date** _____ **Time** _____ **am/pm**

Did (s)he return to work? _____ **Date** _____ **Time** _____ **am/pm**

Did defective equipment or an unsafe condition directly cause the accident? _____

What safeguards should be used in the future?_____

_____

Was this accident caused by another person, or another person's accident? (if so, give details)_____

_____

What do you feel needs to be provided in the future? _____

_____

What do you feel could have, or should have been done that <u>might</u> have prevented the accident? _____

_____

What corrective action has been taken to prevent similar accidents? _____

_____

SUPERVISOR: This form should be completed, signed and submitted to the District Office <u>within 24 hours</u> of the time of the accident.

Supervisor's Signature _____**Date**_____