

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 _____