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:_____

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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_____