MIIA Nonprofit Locally based Member driven
Serving Massachusetts communities since 1982

Town of Westport

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

DATE OF INJURY:_____TIME OF INJURY_____ ACKNOWLEDGE/DATE REPORTED_____

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED?WHY?_____

_____

*CAUSE:_____*NATURE:_____ *BODY PART:_____*OCCUPATION_____

EMPLOYEE NAME_____ SOCIAL SECURITY #_____
SEX(M or F)_____ MARITAL STATUS_____ DATE OF BIRTH_____
DATE OF HIRE_____ DEPARTMENT_____
SUPERVISOR NAME _____ PHONE NUMBER_____
EMPLOYEE ADDRESS_____
TELEPHONE NUMBER: HOME_____WORK_____
CELL_____ EMAIL_____

LOCATION ACCIDENT OCCURRED_____(Include Building or School Name)
INJURED ON PREMISE YES☐ NO ☐
AVERAGE WEEKLY WAGE_____DID EMPLOYEE LOSE TIME FROM WORK? YES☐ NO☐
NUMBER OF DEPENDENTS_____
DID EMPLOYEE RETURN TO WORK YES☐ NO☐
IF YES, DATE RETURN TO WORK:_____ Full Duty YES☐ NO☐ Modified Duty YES☐ NO☐
TIME BEGAN WORK_____
IF NO, LAST DAY WORK_____1ST DAY OF DISABILITY_____5TH DAY OF DISABILITY_____ (calendar days)

WAS MEDICAL TREATMENT SOUGHT? YES☐ NO☐ WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM YES☐ NO☐
WAS THE EMPLOYEE HOSPITALIZED OVERNIGHT AS AN INPATIENT YES☐ NO☐
NAME OF PHYSICIAN OR HEALTHCARE PROFESSIONAL: _____
MEDICAL FACILITY NAME:_____ADDRESS _____CITY_____STATE__ ZIP_____
DATE REPORTED AS WORK RELATED:_____
WITNESS _____
TO WHOM WAS INJURY REPORTED TO _____

*******Supervisor's Complete Below*********

CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY

_____

_____

WAS EMPLOYEE WEARING SAFETY GEAR? YES☐ NO ☐ IF NO, EXPLAIN)_____

ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS_____

_____

REMARKS_____

_____

Investigated By_____ Date_____

Reviewed By_____ Date_____

☐ School Nurse ☐ Supervisor

***See page 2 for selection listing**
Red Font: New OSHA Require data

Westport Community Schools

ACCIDENT/INCIDENT REPORT

This form is to be completed for every accident, minor or severe, occurring to any student or employee of the Westport Community Schools during or after school hours or while engaged in school sponsored activities.

Date of Report: _____

Name: _____ (*Last* *First*) **Home Address:** _____ (*Street* *City* *State* *Zip*)

School: _____ **Gender:** M F **Grade/Class:** _____ **Age:** _____

Accident Details

Time Accident Occurred: _____ **Date of Accident:** _____

PLACE OF ACCIDENT

Place of Accident:

- ☐ *School Building
- ☐ *School Grounds
- ☐ To or From School
- ☐ Home
- ☐ Elsewhere

** If accident occurred on school property complete Location section below.*

School Location:

- ☐ Athletic Field/Playground
- ☐ Auditorium
- ☐ Bathroom
- ☐ Cafeteria
- ☐ Classroom
- ☐ Corridor
- ☐ Gymnasium
- ☐ Locker Room
- ☐ Laboratories
- ☐ Stairs
- ☐ Other *(please explain)*: _____

ACCIDENT DESCRIPTION

Description of Accident:

How did the accident happen? What was the person doing? Where was the person? List specific unsafe acts and conditions present. Specify any machine, tool, or equipment involved.

_____

Nature of Injury: _____

Part of Body Injured: _____

RESPONSE TO ACCIDENT

Person in charge when accident occurred. (Enter Name): _____

Present at scene of accident: Y N

Was parent or other individual notified? Y N **When:** _____ (*Date/Time*) **How:** _____

Name of individual notified: _____

By whom? (Enter Name): _____

Immediate Action Taken:

Describe first aid administered. Was the person sent home? Referred to a physician? Sent to a hospital? Remained in school?

_____

SUPERVISOR REMARKS

_____

Signed: **Nurse:** _____ **Principal:** _____ **Date:** _____

Trainer: _____

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Member Services
Aon, MSC 17668, P.O. Box 549294,
Waltham, Massachusetts 02454
Toll Free (Mass) :888/266-6442
Fax: 617 753-9987

MEDICAL AUTHORIZATION

To: _____ Date:_____

_____

_____

and any other physician, hospital, clinic or medical care provider, presently unknown to me, who may have or subsequently acquire information concerning my physical condition. You are hereby authorized to give MIIA Member Services and/or any of its representatives, all information, facts and particulars, including reports, records, results from diagnostic tests, X-rays and statements of charges which may be requested regarding my medical condition, diagnosis, treatment and to furnish them copies of such reports. You are further authorized to allow any physicians appointed by them to review all such reports, records and X-rays in your possession.

I am willing that a photo static copy of this authorization be accepted with the same authority as the original.

This information is to be used for handling my claim from an occupational injury or illness occurring on or about _____ and for no other purpose, now or in the future.

This authorization is valid for the duration of the above condition.

_____ _____

(Employee's signature) (Date)

Employer: Town of Westport
Name of Employee:_____
SS#: _____ Date of Birth: _____
Claim #:_____ Date of Accident: _____

MIIA Risk Management

ACCIDENT INVESTIGATION REPORT PART 1

Members Name:

Instructions: Supervisors should use this form to report all work-related injuries, illnesses, or "near miss" incidents - no matter the severity. This aids in the identification and correction of hazards and in the prevention of future similar type injuries from occurring. The Supervisor is responsible for contributing to all pages of this report. The Supervisor and Injured Employee must complete the EMPLOYEE's STATEMENT part of this report. All photos can be inserted as images in the Part 2 photo page. All pages must be completed.

This is a report of a work-related: ☐ Injury ☐ Illness ☐ Near Miss ☐ Fatality

Employee Name: Department:

Supervisor's Name: Department:

Date of Occurrence: Incident Time: ☐am ☐pm

Loss of Work Time Began (if none, indicate N/A):

INJURY TYPE (Most serious, check all that apply)

☐ Burn -Heat/Chemical	☐ Strain/Sprain/Break	☐ Animal Bite/Sting	☐ Fatality
☐ Cut, Laceration, Puncture	☐ Inhalation/Reaction	☐ Skin Irritation	☐ Head Trauma
☐ Bruise	☐ Abrasion Scrape	☐ Human Bite	☐ Ambulance Transport
☐ Needlestick	☐ Eye Irritation/Cut/Scratch	☐ Illness	☐ Other
☐ Crushing Injury			Explain:

Parts of the body affected:

DESCRIPTION OF THE INCIDENT (Where, What, Why, When, etc.)

Where, exactly, did the incident occur?

What was the injured employee doing at the time of the incident?

Describe, step-by-step, what led up to the incident (i.e., EE was pruning trees, while on ladder, slipped...).

Please complete all pages

WITNESS INFORMATION (List the names, titles & dept. of anyone witness to the incident.)

Name: Title:

Dept./Other/Phone#:

:

Name: Title:

Dept./Other/Phone#:

Name: Title:

Dept./Other/Phone#:

Investigation report completed by: Date:

Employee's Supervisor: Date:

Department Head: Date:

CAUSES OF THE ACCIDENT

Using the list below, please identify cause(s) or potential cause(s) that contributed to this incident.
Check all that apply.

- ☐ Improper instruction
- ☐ Lack of training or skill
- ☐ Operating without authority tool/eqpt
- ☐ Improper storage of chemicals
- ☐ Poor housekeeping
- ☐ Failure to use proper personal protective equipment
- ☐ Failure to use available tool/equipment
- ☐ Struck by person
- ☐ Struck by object
- ☐ Failure to lockout
- ☐ Inadequate lighting
- ☐ Inadequate ventilation
- ☐ Unsafe lifting
- ☐ Inoperative safety device
- ☐ Unsafe arrangement or process
- ☐ Physical or mental impairment
- ☐ Slip/Fall same level
- ☐ Slip/Fall from height
- ☐ Unsafe clothing
- ☐ Improper maintenance
- ☐ Unsafe/Defective
- ☐ Distraction
- ☐ Improper use of equipment
- ☐ Trip
- ☐ Slip/Wet or Icy surface
- ☐ Caught/Between
- ☐ Vehicle incident

Were the unsafe acts or conditions reported prior to the incident? ☐ Yes ☐ No

Have there been similar incidents or near misses prior to this one? ☐ Yes ☐ No

If 'Yes' provide explanation:

Please complete all pages

ACCIDENT PREVENTION

What changes are recommended to prevent future occurrences of similar incidents?

- ☐ Stop this activity/task
- ☐ Redesign the activity/task
- ☐ Redesign the workstation
- ☐ Train the employee(s)
- ☐ Train the supervisor(s)
- ☐ Other

Explain:

- ☐ Enforce existing policy/procedure
- ☐ Develop a new policy/procedure
- ☐ Additional personal protective equipment
- ☐ Additional oversight by supervisor(s)
- ☐ Routinely inspect for the hazard
- ☐ No Change recommended at this time

LIST BELOW RECOMMENDATIONS FOR PREVENTION AND IMPROVEMENT

Recommendations:

What should be (or has been) done to facilitate the recommendations identified above?

EMPLOYEE'S STATEMENT

Employee needs to complete this form with along with the Supervisor to aid in the identification of hazards, deduce a corrective action and sign-off on corrective action completion.

Date of incident: Where, exactly, did the incident occur?

Describe step-by-step, what led up to the incident; and include if proper protective equipment was being worn or provided.

What/How do you feel this could have prevented this incident/injury?

Was proper training provided?

Please provide corrective action or suggestion for preventing future similar type incidents.

Employee's Signature: _____ Date:

Name:

Supervisor's Signature: _____ Date:

Name:

Please complete all pages