

Selah School District

ACCIDENT // INCIDENT // INJURY REPORT

THIS IS NOT A WORKER'S COMPENSATION CLAIM FORM! IT DOES NOT REPLACE A NOTICE OF CLAIM OR PETITION FOR WORKER'S COMPENSATION BENEFITS! (Complete within 24 hours - to Supervisor)

SCHOOL DISTRICT: _____ **SCHOOL:** _____

WHO: PERSON INJURED / ILL: _____
CHECK ONE: EMPLOYEE CONTRACTOR

OCCUPATION: _____ IMMEDIATE SUPERVISOR: _____

WITNESSES or OTHER PEOPLE INVOLVED: _____

PLEASE IDENTIFY OTHERS by NAME and INVOLVEMENT, such as JOHN JONES, WITNESS; JANE JONES, OTHER DRIVER

WHEN: DATE _____ TIME _____ AM/PM

REPORTED to: _____ DATE _____ TIME _____ AM/PM
NAME, TITLE, TELEPHONE NUMBER

LAST DAY WORKED: _____ DATE YOU EXPECT to RETURN to WORK: _____

WHERE: _____
EXACT LOCATION

WHAT: Describe the circumstances, surroundings, events, and behaviors leading up to the accident/incident/injury. Use back of sheet, if necessary, to describe or draw a diagram to help explain.

Were you injured? Yes No Describe your injury, including all body parts affected, and specify Right Side or Left Side: _____

Describe any other results of the incident you think are important, including injury to others, property damage, etc. _____

WHY: Explain, as best you can, why it happened.

Explain, as best you can, why the causes were present: _____

HOW do you recommend that recurrence or similar incidents be prevented? _____

EMPLOYEE COMMENT: Anything else you think is important, or want the Claims Manager to know::

**** SIGN and DATE: ****

EMPLOYEE: _____ **DATE:** _____

SUPERVISOR: _____ **DATE:** _____

DISTRICT CLAIMS MGR/ ADMIN: _____ **DATE:** _____