

Lakeview School District SUPERVISOR'S REPORT OF ACCIDENT

Location – _____

Employee's Name	First	Middle	Last	Soc Sec No	Age	Sex
Home Address	Occupation					
Date of Accident	Time of Accident		OA.M OP.M.	Department		
Describe Injury				Regular Work?		

Fatality? Circle - No Yes

<u>How Did Accident Happen?</u>	Employment Date	How Long On This Job?
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Machine Or Equipment Involved?

Acts Performed

Conditions

What Should Be Done To Prevent Repetition?
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Has It Been Done?	If Not, Give Reason
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Name of Physician	Address
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Name of Hospital	Address
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Supervisor's Signature	Date	Reviewed By	Date
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