

# **BARTLETT CITY SCHOOLS INJURY / ACCIDENT REPORT**

*This must be filled out by the injured employee's Supervisor, verified by the injured employee, signed by the injured employee and Supervisor and turned into The Personnel Office within 24 hours.*

- MAJOR     MINOR     NOTIFY ONLY     FIRST AID     REMAINED AT WORK  
 RETURNED TO WORK     SENT TO DOCTOR     SENT TO HOSPITAL     SENT HOME

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## **INJURED EMPLOYEE**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone No.: \_\_\_\_\_

Department: \_\_\_\_\_

Birthday: \_\_\_\_\_

Social Security: \_\_\_\_\_

Male     Female     Single     Married

Part Time     Full Time

Date & Time Reported: \_\_\_\_\_

Date & Time Injured: \_\_\_\_\_

Person Notified: \_\_\_\_\_

Date of Hire: \_\_\_\_\_

Time Shift Started: \_\_\_\_\_

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## **THE ACCIDENT (OR EXPOSURE TO OCCUPATIONAL DISEASE)**

Location of Accident (Address or Street) \_\_\_\_\_

(City) \_\_\_\_\_ (County) \_\_\_\_\_ Was it on employer's premises? \_\_\_\_\_

What was the employee doing when injured?

*(Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from a hand sprayer"; "daily computer key-entry.")* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did the accident occur? *(Examples: When ladder slipped on wet floor, the worker fell 20 feet"; "Worker was sprayed with chlorine when a gasket broke during replacement"; "Worker developed soreness in wrist over time.")*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# INJURY (OR OCCUPATIONAL DISEASE)

Describe the injury or disease in detail (example: amputation of right index finger; fracture of right upper left arm; fracture of ribs; lead poisoning, etc.) \_\_\_\_\_

Name the object or substance which directly injured the employee:

(Example: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to incident, leave it blank)

Was employee able to return to work the same day?  Yes  No

Did employee die?  Yes  No If Yes, date of death (If known):

Name and address of physician (If applicable): \_\_\_\_\_

If hospitalized, name and address of hospital: \_\_\_\_\_

Describe what has been or will be done to prevent similar injuries: \_\_\_\_\_

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## What was the basic cause of the accident? (Check any or all that apply)

### A. SUPERVISORY RESPONSIBILITIES

- No Instructions given
- Incomplete instructions
- Rules, standards or instructions not enforced
- Personal protection equipment not provided
- Correct or safe tools or equipment not provided
- Inadequate inspection of equipment or jobs
- Improper method of doing work
- Poor job planning
- Rushing job

### B. PERSONAL ACTION OF EMPLOYEE

- Haste or short cuts
- Proper equipment not used
- Improper or unsafe tools or equipment used
- Horseplay
- Instructions disregarded
- Inattention
- Inexperience
- Physical condition of employee
- Improper body position
- Improper method of doing work
- Action of fellow employee

### C. UNSAFE EQUIPMENT OR MATERIAL

- Ineffectively guarded equipment
- Unguarded equipment
- Defective materials
- Defective tools
- Defective equipment (not motor vehicles)
- Defective motor vehicle equipment
- Unsafe equipment or material of contractor non-employee
- Improper type or poor design

### D. UNSAFE CONDITIONS

- Poor light
- Poor ventilation
- Bad housekeeping
- Improper piling or storing
- Tools, equipment or materials scattered around
- Slippery floors or walkways
- Unsafe condition caused by contractor, non-employee
- Faulty layout of facilities
- Exits or emergency escapes inadequate or not provided
- Other:

Sign \_\_\_\_\_

Print \_\_\_\_\_

Date \_\_\_\_\_

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**Supervisor** (By signing I have verified that all above information is true and accurate to the best of my knowledge)

Sign \_\_\_\_\_

Print \_\_\_\_\_

Date \_\_\_\_\_

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**Injured Employee** (By signing I have verified that all above information is true and accurate to the best of my knowledge)