

# Supervisor's Incident Investigation Form

(This is **NOT** a Workers' Compensation benefits claim form)

The injured worker **must** complete Part One and submit it to his/her supervisor.

The injured worker's supervisor **must**:

- Perform an investigation of the incident,
- Complete Part Two of this form, and
- Submit the entire report to the NEWESD 101 Risk Manager.

## Part One—To be completed by the injured employee.

Employee's Name Last: \_\_\_\_\_ First : \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Employee's Home Address: \_\_\_\_\_

ZIP \_\_\_\_\_ Home Phone \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Last 4 Social Security # \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

School District Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

School/Building: \_\_\_\_\_ Department: \_\_\_\_\_

Supervisor's Name and Job Title: \_\_\_\_\_

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_ Day of Week: \_\_\_\_\_

Date of Incident Report: \_\_\_\_\_ Reported to Whom: \_\_\_\_\_

Specific location where incident occurred: \_\_\_\_\_

Witnesses: #1 \_\_\_\_\_ Ph# \_\_\_\_\_

#2 \_\_\_\_\_ Ph# \_\_\_\_\_

Complete description of the incident: \_\_\_\_\_

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

Describe your injuries including body part(s) & specific injury: \_\_\_\_\_

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

**If you are injured at work and see a doctor, you must call  
509-789-3516 or 1-800-531-4290  
to file a claim for Workers' Compensation benefits**

Have you already filed a claim form? (This is **NOT** a claim form!) Yes  No

Did you miss work as a result of this incident? Yes  No

If "yes" -- List the date(s): \_\_\_\_\_

Did you see a doctor? Yes  No

If yes, name, address, phone of physician/clinic: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Employee Signature required*

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**Part Two—To be completed by the injured employee's supervisor.**

**Supervisor's comments**—Describe the incident in your own words: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What could have been done to prevent this incident? \_\_\_\_\_  
\_\_\_\_\_

Have all unsafe conditions been corrected? Yes  No   
If "yes" -- What has been done? \_\_\_\_\_

If "no" -- What needs to be done? \_\_\_\_\_

Have all unsafe activities been addressed? Yes  No   
If "yes" -- What has been done? \_\_\_\_\_

If "no" -- What needs to be done? \_\_\_\_\_

Has additional Personal Protective Equipment (PPE) been provided as a result of the incident?  
Yes  No

List the PPE: \_\_\_\_\_

If "yes" -- Who received the additional PPE? \_\_\_\_\_

Has additional training been provided as a result of this incident? Yes  No   
If "yes" -- Who received the additional training? \_\_\_\_\_

**Print Supervisor's name:** \_\_\_\_\_ **Position/Title** \_\_\_\_\_

Phone number \_\_\_\_\_ Email: \_\_\_\_\_

**Supervisor's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Supervisor Signature required*

Additional comments/notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE SUBMIT COMPLETED FORM TO HUMAN RESOURCES WITHIN 48 HOURS OF THE INCIDENT**

