# NON-EMPLOYEE INCIDENT/ACCIDENT REPORT FORM

## CLARKSDALE MUNICIPAL SCHOOL DISTRICT

SURNAME / FAMILY NAME: _____

FIRST NAME: _____

DAY AND DATE OF INCIDENT: _____ (Day) _____ (Date)

TIME OF INCIDENT: _____ TIME SHIFT COMMENCED: _____

USUAL EMPLOYMENT LOCATION: _____

LOCATION OF INCIDENT: _____
SITE NAME OR UNIQUE REFERENCE NUMBER

EXACT LOCATION OF ACCIDENT: _____
EXAMPLE-NEAR MAIN ENTRANCE, STOREROOM, IN CAR PARK, BEHIND WORKSHOP, ETC.

WHAT WAS THE INJURY OR INCIDENT: _____
GIVE FULL DETAILS-EG: CUT ON LITTLE FINGER ON LEFT HAND, SLIP ON WET FLOOR, ETC.

HOW DID THE INCIDENT HAPPEN? WHAT WERE YOU DOING WHEN THE INCIDENT OCCURRED?
(DESCRIBE IN DETAIL WHAT CAUSED THE INCIDENT. ATTACH ADDITIONAL INFORMATION IF NECESSARY)

_____

_____

_____

_____

WHAT PROTECTIVE EQUIPMENT WAS BEING USED OR WORN AT THE TIME OF THE ACCIDENT?

_____

_____

DESCRIBE ANY MEDICAL TREATMENT OR FOLLOW UP ACTION REQUIRED AFTER THE INCIDENT?

_____

_____

WAS ANYONE ELSE INVOLVED IN THE INCIDENT? IF YES, PLEASE PROVIDE DETAILS.

_____

_____

CONSEQUENCE OF INCIDENT

INJURY

- ☐ Fatality
- ☐ Lost Time (Not available for normal work the day after an injury)
- ☐ Medical Treatment
- ☐ First Aid
- ☐ No Injury

PERSON AFFECTED

- ☐ Customer
- ☐ Employee
- ☐ Contractor

PROPERTY DAMAGE

- ☐ Building: $_____
- ☐ Tools: $_____
- ☐ Plant: $_____
- ☐ Other: $_____

Witness's names and contact number (attach witness statements if available)

| Name | Contact Details |
|---|---|
| | |
| | |

To whom was the accident reported? _____

When was the accident reported? _____

In your opinion, what action, if any, could be taken to prevent a recurrence of the incident?

_____

_____

Was an ambulance called? ☐ No ☐ Yes Incident No: _____

Were the police called? ☐ No ☐ Yes Incident No: _____

Was Trauma Counseling Offered? ☐ No ☐ Yes Date Contacted: _____

Was Medical Treatment Sought? ☐ No ☐ Yes Location: _____

Date & Time: _____

_____ _____ _____

Employee Name Signature Date

SUPERVISORS USE ONLY

To whom was the accident reported? _____

Date and time accident reported. _____

Supervisors' Comments & Initial Investigation Notes: _____

_____

Target date for follow up action: _____

Follow up action to be performed by whom? _____

Will the injured employee be off work for more than 7 calendar days? ☐ No ☐ Yes

Have all possible actions been taken to prevent a re-occurrence? ☐ No ☐ Yes

_____ _____

Supervisor's Signature & Name Date Signed