PRINT FORM

WEST SENECA CENTRAL SCHOOL DISTRICT
ACCIDENT/INVESTIGATION REPORT

SUBMIT TO BUSINESS OFFICE WITHIN 24 HOURS OF INCIDENT

Incident Date: _____ Time Occurred: _____ Date Reported: _____
Employee Name: _____ Sex: M ☐ F ☐ D.O.B.: _____
Address: _____ City/Town: _____ State: _____ ZIP: _____
E-mail Address: _____ Home Phone: _____ Cell Phone: _____
SS #: _____ Date of Hire: _____ Full Time ☐ Part Time ☐ Substitute ☐
Days Worked: M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ SU ☐ 10 Mo. Emp. ☐ 11/12 Mo. Emp. ☐
Time of Day Employee Began Work: _____ Wages/Hour: _____
Occupation: _____ How Long Employed in Current Occupation: _____
Job Location: _____
Person Reported to: _____ Orally ☐ In Writing ☐
Witness(es): _____
Location of Incident: _____
Description of Incident: _____
_____
Source of Injury: _____
Nature of Injury: _____
Body Part(s) Involved: _____
Major Cause of Accident: _____
Has it been Corrected? Yes ☐ No ☐ If Yes, How: _____
If No, Why not? _____
What steps have been taken to prevent similar incidents? _____
What steps should be taken to prevent a recurrence? _____
Any Property, Product or Equipment Damage? Yes ☐ No ☐ Motor Vehicle Accident? Yes ☐ No ☐
If Yes, Describe: _____
Who Provided Medical Care? _____ When? _____
Doctor: _____ Hospital: _____
Ongoing Treatment for Accident? Yes ☐ No ☐ Date Stopped Work Due to Accident: _____
Employee Paid for Full Day on Day of Accident? Yes ☐ No ☐ Salary Continuation? Yes ☐ No ☐
Date Returned to Work (RTW): _____ RTW Full Duty? ☐ RTW Restricted Duty? ☐

MUST HAVE DOCTOR'S EXCUSE FOR ANY LOST TIME

How serious was the injury? *(Check one)*

- ☐ Did not require treatment more than First Aid.
- ☐ Required treatment more than First Aid, but did not result in lost time.
- ☐ Resulted in lost time. (See above)
- ☐ Restricted activity.
- ☐ Resulted in death.

EMPLOYEE STATEMENT: _____
_____

I HAVE READ THIS REPORT AND IT IS CORRECT.

EMPLOYEE SIGNATURE: _____ DATE: _____
SUPERVISOR'S NAME (*Print*): _____
SUPERVISOR'S SIGNATURE: _____ DATE: _____