Kansas Association of School Boards
Supervisor's Accident Investigation Report

This report is to be completed by the injured person's supervisor before the end of the shift during which the accident or illness occurred.

NAME OF INJURED PERSON:_____

AGE: _____EMPLOYMENT STATUS FULL-TIME☐ PART-TIME☐ VOLUNTEER☐

DATE OF ACCIDENT:_____DAY OF ACCIDENT:_____TIME:_____A.M. / P.M.

DEPARTMENT:_____OCCUPATION:_____

HOURS INTO SHIFT WHEN OCCURRED:_____HOW LONG EMPLOYED?_____

EXACT LOCATION OF ACCIDENT:_____

WAS ACCIDENT SITE REVIEWED BY SUPERVISOR? Yes☐ No☐

DID SUPERVISOR INTERVIEW INJURED PERSON? Yes☐ No☐

DID SUPERVISOR INTERVIEW WITNESSES? Yes☐ No☐

EXACTLY HOW DID ACCIDENT OCCUR? DESCRIBE PERSONS, ACTION, EQUIPMENT, CONDITIONS, ETC.:

_____

_____

_____

WAS EMPLOYEE WEARING/USING REQUIRED SAFETY EQUIPMENT? Yes☐ No☐ N/A☐

WHAT EQUIPMENT COULD HAVE BEEN UTILIZED TO PREVENT THIS ACCIDENT?

_____

_____

IS THIS EQUIPMENT AVAILABLE FOR EMPLOYEE USE? Yes☐ No☐

FOR EACH OF THE FOLLOWING FACTORS, INDICATE WHAT COULD BE IMPROVED TO PREVENT THIS ACCIDENT:

TRAINING

_____

_____

_____

COMMUNICATIONS

_____

_____

_____

POLICIES/PROCEDURES

_____

_____

_____

INSPECTIONS/OBSERVATIONS

_____

_____

_____

WHAT IMMEDIATE ACTION HAS BEEN TAKEN TO PREVENT THE RECURRENCE OF A SIMILAR ACCIDENT?

_____

REPORT BY INJURED EMPLOYEE ATTACHED? Yes ☐ No ☐

REPORTS OF EYEWITNESSES ATTACHED? Yes ☐ No ☐

WAS FIRST AID ADMINISTERED ON THE SCENE? Yes ☐ No ☐

WHO AUTHORIZED MEDICAL TREATMENT?_____

SUPERVISOR SIGNATURE:_____ DATE:_____

****

TO BE ROUTED TO:

****

TO BE FILLED OUT BY THE DEPARTMENT DIRECTOR

COMMENTS:_____

_____

_____

SIGNATURE_____ DATE_____

TO BE COMPLETED BY SAFETY COORDINATOR

COMMENTS:_____

_____

_____

SIGNATURE_____ DATE_____

TO BE COMPLETED BY SUPERINTENDENT

COMMENTS:_____

_____

_____

SIGNATURE_____ DATE_____

KASB
Workers Compensation Fund, Inc.

REPORT BY INJURED EMPLOYEE

Employer:_____

Your Name:_____

Your Home Address:_____

Your Home Phone Number:_____

Social Security Number:_____

Date of Accident:_____Time of Accident:_____

In your own words, please describe what happened:_____

_____

_____

_____

What physical problems do you relate to this injury?_____

_____

_____

Did you report this injury to your supervisor?_____If not, why not?_____

Date Reported?_____Supervisor's Name:_____

Were you working at your regular job at the time of the injury?_____If not, please explain:

_____

_____

_____

Were there any witnesses?_____If yes, who?_____

_____

Did you go to a hospital/clinic? Yes☐ No☐

Address of hospital/clinic:_____

Name of treating physician:_____

Any additional comments:_____

_____

_____ _____

Date Signature

KASB
Workers Compensation Fund, Inc.

REPORT BY EYEWITNESS

Name:_____

Name of Injured Employee:_____

Name of Witness:_____

Address:_____

Telephone Number:_____

Date of Incident:_____

In your own words, describe what you saw happen:

_____

_____

_____

Did anyone else see the accident? ☐ Yes ☐ No

If yes, please list their name(s)?_____

_____

Other comments:_____

_____

Signature of Eyewitness:_____