



## 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.:

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

WHAT EQUIPMENT COULD HAVE BEEN UTILIZED TO PREVENT THIS ACCIDENT?

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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

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COMMUNICATIONS

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POLICIES/PROCEDURES

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INSPECTIONS/OBSERVATIONS

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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: \_\_\_\_\_

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**TO BE ROUTED TO:**

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**TO BE FILLED OUT BY THE DEPARTMENT DIRECTOR**

COMMENTS: \_\_\_\_\_

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SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**TO BE COMPLETED BY SAFETY COORDINATOR**

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**TO BE COMPLETED BY SUPERINTENDENT**

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_