CLARKSDALE MUNICIPAL SCHOOL DISTRICT

NON-EMPLOYEE INCIDENT / ACCIDENT REPORT FORM

1. INCIDENT INFORMATION

Surname / Family Name _____

First Name _____

Date of Incident _____

Time of Incident _____

Time Duty Commander _____

Usual Employment Location _____

Location of Incident _____

Op. Name or Reference Number _____

Exact Location of Incident _____

(Example: Main Entrance, Cafeteria, Parking Lot, Gymnasium, Playground)

2. INCIDENT DESCRIPTION

What was the injury or incident? _____

How did the incident happen? What were you doing when the incident occurred? _____

What particular equipment was being used or worn at the time? _____

Describe any medical treatment or follow-up action required. _____

Was anyone else involved in the incident? If yes, provide details. _____

3. CONSEQUENCES OF INCIDENT

INJURY

- ☐ Fatality
- ☐ Lost Time
- ☐ Medical Treatment
- ☐ First Aid
- ☐ No Injury

PERSON AFFECTED

- ☐ Visitor
- ☐ Volunteer
- ☐ Contractor
- ☐ Vendor
- ☐ Other _____

PROPERTY DAMAGE

- ☐ Building — Estimated Cost $ _____
- ☐ Equipment — Estimated Cost $ _____
- ☐ Vehicle — Estimated Cost $ _____
- ☐ Other — Estimated Cost $ _____

4. WITNESS INFORMATION

Witness Name	Contact Information

5. DESCRIPTIVE INFORMATION

To whom was the accident reported? _____

When was the accident reported? _____

What action could be taken to prevent recurrence? _____

6. CONTRIBUTORY FACTORS

Were an authorized visitor?	☐ Yes	☐ No	Incident Number _____
Were you on school premises pursuant contract?	☐ Yes	☐ No	Incident Number _____
Were trained on related safe practices?	☐ Yes	☐ No	Date Generated _____
Was medical treatment sought?	☐ Yes	☐ No	Location _____
			Date & Time _____

7. CERTIFICATION

I certify that the information contained in this report is true and accurate to the best of my knowledge.

Printed Name _____ Signature _____ Date _____

8. SUPERVISOR / ADMINISTRATOR USE ONLY

Rule and Statute violated (if any): _____

Initial Investigation Notes: _____

Target Date for Follow-Up Action: _____

Assigned To: _____

Follow-Up/Final action (to include departments involved):

Has more than seven (7) calendar days? ☐ No ☐ Yes

Was all information/facts have been taken to prevent recurrence? ☐ No ☐ Yes

Supervisor Signature: _____

Date Completed: _____