LAKE COUNTY OFFICE OF EDUCATION

TO TEACH. TO SERVE. TO LEARN.

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

This report is intended to be confidential for transmission to attorneys for the District in the event that litigation arises out of this incident.

☐ INCIDENT ONLY ☐ EMPLOYEE TO SEEK MEDICAL ATTENTION

NAME OF INJURED:____

MAILING ADDRESS OF INJURED: ____________________________________

CITY: ________________STATE/ZIP: _____________ DATE OF HIRE: ____________

SOCIAL SECURITY NUMBER: _________________ DATE OF BIRTH: ______________

HOME/CELL PHONE NUMBER: _______________________________________

JOB TITLE/SITE:___________________________________SEX: ( ) MALE ( ) FEMALE

DESCRIBE INJURY, STATE SPECIFIC BODY PART(S) INVOLVED: (IE: RIGHT HAND, LEFT FOOT) AND HOW THE INJURY OCCURRED:

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DATE OF INCIDENT:_______________ HOUR:_________________PHOTOS<'""""'Y'""""""'N

DATE REPORTED:_________________ HOUR:_______________________

ACCIDENT LOCATION AND ADDRESS: ____

WITNESSES: NAMES; ADDRESSES; PHONE NUMBERS

1.____

2.____

<u>FIELD INVESTIGATION (TO BE COMPLETED BY SUPERVISOR)</u>

TIME NOTIFIED__________ TIME ON SCENE___________ TIME OFF SCENE___________

Completely describe location of incident: including lighting, walking surface, weather, measurements, and any other condition that could have contributed to or prevented the incident.

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Describe injuries/illnesses which you observed or which were described to you:_______________

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Describe demeanor of person involved and include statements made as "Excited Utterances":

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Describe shoes, physical appearance or any other characteristic that would contribute to understanding how the accident occurred: ____

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Describe how the incident occurred; state facts, contributing factors, cite witnesses and support evidence:____

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Steps taken to prevent similar incident:____

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Did employee seek medical care? (Check one) Yes ☐ No ☐

If so, what type of medical care did they seek?

- ☐ **Company Nurse Injury Hotline (1-877-518-6702)**
- ☐ **Emergency Room Name/Location of Facility:** ___________________________
- ☐ **Personal Primary Physician* Name:**

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Please note:** The employee can only been seen by their Personal Primary Physician if a ***Designation of Physician Form is on file with Human Resources, <u>prior to the incident,</u> designating that your physician <u>accepts</u> worker's compensation claims. Contact Human Resources at (707) 262-4151 if questions.

___________________________ ___________________________ ____________________
Name of Injured Worker Signature Date

____
Investigator/Supervisor's Signature Date/Time form completed

Submit to Human Resources <u>Immediately</u> Upon Completion -
fax: (707) 263-0197 or email: kandees@lakecoe.org

Updated 9/2015 kss