BIRDVILLE INDEPENDENT SCHOOL DISTRICT
SUPERVISOR ACCIDENT INVESTIGATION FORM

INSTRUCTIONS:

In an effort to provide and promote a safe working environment, the immediate supervisor of an employee injured on the job or experiencing an occupational exposure to blood (other than their own) or other potentially infectious material should investigate all injuries and file this report within **forty-eight (48) hours of the injury.** Immediate supervisors include central administrators, principals, directors, maintenance & custodial supervisors, head custodians, and cafeteria managers. PRINT all information requested on this form. After completing the form, send to the **Attn: Workers' Comp. Office.**

Name: _____ Title: _____

Date report completed: _____

ACCIDENT INFORMATION

Injured employees name: _____ Title: _____

Facility or Dept. assigned to: _____

Date of incident: _____ Time of incident: _____ a.m./p.m.

Facility where incident occurred: _____

Location of incident within facility (kitchen, classroom, office, etc.):

When was the incident reported to you:

Date reported: _____ Time reported: _____ a.m./p.m.

Was employee performing regular duties: YES or NO

Did injured employee seek medical treatment from a doctor or nurse: YES or NO

If no, EXPLAIN:

List any protective equipment the employee was wearing when injured (back support belt, gloves, eye wear, etc.):

What injuries did the employee report (body part(s) affected, type of injury):

(CONTINUE ON BACK)

List any circumstances or conditions that you believe contributed to the accident:

What action has been taken to correct and/or eliminate any contributing factors:

What corrective action should be taken to avoid a recurrence of this type of injury:

I hereby acknowledge that the above information is true and correct to the best of my knowledge.

Signature **Date**

FOR OFFICE USE ONLY:

Please fax and interoffice this form to the <u>BIRDVILLE WORKERS' COMP OFFICE</u> Fax: (817) 547-5533