Complete form by obtaining hard copy from secretary or fill out online, print, sign and send to DO

Crook County School District
Employee Accident Report

EMPLOYEE TO COMPLETE

PART 1: PERSONAL IDENTIFICATION

Employee Group
- ☐ Employee
- ☐ Visitor
- ☐ Volunteer

Name (Last, First) | Department / Job Title

Home Address | Work Phone | Home Phone

Supervisor Name (Last, First) | Title | Work Phone

Work Schedule
- ☐ Full-Time
- ☐ Part-Time

PART 2: INCIDENT DESCRIPTION

Date of Incident | Time of Incident | Location of Incident (Street address or Bldg name, Room#)

Body part(s) injured | Right / Left ☐ ☐

- **Describe step-by-step events leading up to the incident in detail** (what you were doing? Lifting/outdoors, using tools/machinery, chemicals/fumes)

• Specific task being performed at time of incident:	
• Equipment/ tools involved:	
• Materials being handled:	
• Unusual condition(s):	
• Other relevant details:	

Was the accident/illness:
☐ A Sudden, Specific Event/Occurrence? 2 ☐ Gradually Occurring Over Time? 3 ☐ An Occupational Disease? 4 ☐ Fatality?

Treatment: ☐ None ☐ First Aid Only ☐ Doctor ☐ Hospital ☐ Refused
Treating Physician:_____
Phone: _____

Employee Signature* | Date

* Signing of this form does not constitute acceptance of individual fault

_____Supervisor/Admin. to complete next page_____

***Note: Complete entire Workers Compensation claim (Form 801 or 801s) if injury required doctor's treatment. Turn into the CCSD HR Dept. when completed. Form 801 or 801s must be received by SAIF within five (5) days of your knowledge of doctor treatment.**

☐ Near-Miss
☐ First Aid
FILE 801, IF BOXES BELOW ARE CHECKED
☐ Medical Care
☐ Time Loss
☐ Fatal

Crook County School District
INCIDENT ANALYSIS

Immediate supervisor should complete this form promptly with worker.

SYSTEM CHALLENGES

Management:
Do we have;
Policy Enforcement
Hazard Recognition
Accountability
Supervisor Training
Corrective Action
Production Priority
Proper Resources
Job Safety Training
Hiring Practices
Maintenance
Adequate Staffing
Safety Observations

Employee:
Was the employee;
Following Procedure
Training
Previous Injury
Mental Ability
Physical Capacity
Equipment Use
Short Cuts
PPE Worn
Safety Attitude

Equipment:
Do we have;
Proper Tool Selection
Tool Availability
Maintenance
Visual Warnings
Guarding

Environment:
What about;
Plant Layout
Chemical
Temperature
Noise
Radiation
Weather
Terrain
Vibration
Ergonomics
Lighting
Ventilation
Housekeeping
Biological

Additional Causal Factors
☐ Faulty Equipment
☐ Non-Employee
☐ Prior Injury
☐ Late Reporting
☐ Off-the-Job Injury
(Explain any checked boxes on separate sheet)

1. Employee _____ Dept. _____ Phone #_____

   Employer _____

2. Date/Time of Incident _____ Date/Time First Reported_____

   Supervisor _____ Dept _____ Phone # _____

3. Incident Location _____

4. Describe Injury (Nature of Injury/Part of Body) _____

5. Describe Incident Fully (What happened):

6. Identify factors that **ARE NOT WORKING**. **(refer to list on left side of page):**

Management:	**Employee:**
Equipment:	**Environment:**

Counter Measures/Best Practice; **How do we correct areas identified in the MEEE area above, who will make changes and when will the changes be completed. Use other sided if needed.**	**Who**	**By When**

7. Treating Physician, if known _____ Phone _____

Completed by: _____ Title _____

Employee Signature: _____ Date/Time: _____

Note: Complete Workers Compensation claim (Form 801) if injury required doctor's treatment. Form 801 must be received by insurance carrier within five (5) days of your knowledge of doctor treatment.