SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

The injured employee's **supervisor** shall complete the Accident Investigation Report immediately following an illness or injury.

Revised 08/2020

Provide as much detail as possible. PLEASE PRINT OR TYPE

PLEASE EMAIL OR MAIL A COPY OF THIS REPORT TO SIPE WITHIN 10 BUSINESS DAYS.

Save

GENERAL DATA

DATE OF REPORT _____

SCHOOL DISTRICT *Choose a District*	SCHOOL SITE	SITE PHONE
EMPLOYEE NAME (PRINT)	YEAR OF BIRTH (YYYY)	GENDER ☐ MALE ☐ FEMALE
OCCUPATION (REGULAR JOB TITLE)	DATE EMPLOYER WAS NOTIFIED OF INCIDENT	DATE THE EMPLOYEE WAS PROVIDED WITH DWC-1 FORM

EMPLOYEE USUALLY WORKS

____ HRS/DAY ____ DAY/WEEK ____ TOTAL HRS/WEEK

EMPLOYMENT STATUS (CHECK APPLICABLE STATUS AT TIME OF INJURY)

☐ FULL TIME ☐ PART TIME ☐ TEMPORARY ☐ SEASONAL

DATE OF INCIDENT	TIME OF INCIDENT	TIME EMPLOYEE BEGAN WORK	IF EMPLOYEE DIED, DATE OF DEATH
	____ : ____ AM ____ : ____ PM	____ : ____ AM ____ : ____ PM	

UNABLE TO WORK AT LEAST ONE FULL DAY **AFTER** DATE OF INJURY?	LAST DAY WORKED	DATE RETURNED TO WORK	IF STILL OFF WORK, EXPECTED RETURN DATE
☐ YES ☐ NO			

IF THE PHYSICIAN IS **NOT** FROM THE RECOMMENDED MEDICAL CLINICS FOR WORKERS' COMPENSATION INJURIES, DOES THE EMPLOYEE HAVE A FORM ON FILE TO SEE A PERSONAL PHYSICIAN? ☐ YES ☐ NO

WHO TRANSPORTED THE EMPLOYEE TO THE DOCTOR?	DID THE INJURY OCCUR ON SCHOOL DISTRICT PROPERTY? ☐ YES ☐ NO IF NO, LOCATION OF INCIDENT _____
WAS THE INCIDENT SCENE VISITED AS PART OF THIS INVESTIGATION? IF YES, BY WHOM? ☐ YES ☐ NO _____	WERE PHOTOS TAKEN AT THE SITE OF THE INCIDENT? *IF YES, INCLUDE WITH REPORT* ☐ YES ☐ NO

NAME OF SUPERVISOR

INJURY/ILLNESS DATA

PLEASE CHECK ALL THAT APPLY

CLASS OF INJURY

☐ FATALITY ☐ LOST WORKDAY ☐ RESTRICTED WORK ☐ MEDICAL ONLY ☐ FIRST AID ☐ FOR RECORD ONLY

NATURE OF INJURY

☐ ABRASIONS ☐ AMPUTATION ☐ BITES/STINGS ☐ BURNS ☐ CONCUSSION ☐ CONTUSION ☐ CRUSHING ☐ DISLOCATION ☐ FOREIGN BODY ☐ FRACTURE ☐ HEARING LOSS ☐ HEAT EXHAUSTION/ STROKE ☐ HERNIA ☐ INFECTIOUS DISEASE ☐ LACERATION ☐ MENTAL DISORDER ☐ POISONING ☐ PUNCTURE ☐ RASH ☐ REPETITIVE MOTION ☐ RESPIRATORY ☐ STRAIN/SPRAIN ☐ OTHER _____

PART OF BODY AFFECTED

☐ ABDOMEN ☐ ANKLE ☐ ARM ☐ BACK ☐ CHEST ☐ ELBOW ☐ EYES ☐ FINGER ☐ FOOT ☐ HAND ☐ HEAD ☐ HIP ☐ KNEE ☐ LEG ☐ NECK ☐ SHOULDER ☐ TEETH ☐ TOE ☐ WRIST ☐ FACE

SIDE OF BODY AFFECTED

☐ RIGHT ☐ LEFT

TYPE OF ACCIDENT

☐ ASSAULT OR VIOLENCE ☐ BODILY REACTION ☐ CAUGHT IN, UNDER OR BETWEEN ☐ EXPOSURE ☐ FALL FROM ELEVATION ☐ FALL TO FOOT LEVEL ☐ FIRE OR EXPLOSION ☐ MOTOR VEHICLE ☐ OVEREXERTION ☐ SLIP ☐ STRUCK AGAINST ☐ STRUCK BY ☐ TRIP ☐ OTHER _____

SOURCE OF INJURY

☐ AIR PRESSURE ☐ ANIMAL ☐ CHEMICAL ☐ ELECTRICAL ☐ ENVIRONMENTAL ☐ EXTREME TEMPERATURE ☐ HAND TOOL ☐ HUMAN ☐ INFECTIOUS AGENT ☐ INSECT ☐ LADDER/SCAFFOLD ☐ LIFTING/CARRYING ☐ MACHINERY ☐ NEEDLESTICK ☐ NOISE ☐ PARTICULATES ☐ PARTS & MATERIALS ☐ POWER TOOL ☐ PUSHING OR PULLING ☐ STAIRS ☐ VEGETATION ☐ VEHICLE ☐ WORKING SURFACE ☐ OTHER _____

UNSAFE CONDITIONS

☐ DEFECTIVE TOOLS/EQUIPMENT ☐ ENVIRONMENTAL HAZARD ☐ EXCESSIVE NOISE ☐ HAZARDOUS WORKSURFACE ☐ IMPROPER DESIGN ☐ IMPROPER USE OF TOOLS ☐ IMPROPER WORKSPACE ☐ INADEQUATE GUARDING ☐ INADEQUATE ILLUMINATION ☐ INADEQUATE VENTILATION ☐ LACK OF MAINTENANCE ☐ LACK OF WARNING SIGNS ☐ POOR DESIGN ☐ POOR HOUSEKEEPING ☐ UNPREDICTABLE ACTIONS ☐ UNSUITABLE MATERIAL ☐ OTHER _____

UNSAFE ACT

☐ CREATING ADDITIONAL HAZARDS ☐ FAILURE TO FOLLOW INSTRUCTIONS OR PROCEDURES ☐ FAILURE TO IDENTIFY A HAZARD ☐ FAILURE TO INSPECT EQUIPMENT ☐ FAILURE TO USE PPE ☐ HORSEPLAY ☐ IGNORED KNOWN HAZARD ☐ IMPROPER LIFT/CARRY ☐ INATTENTION TO FOOTING OR SURROUNDINGS ☐ JUMP FROM ELEVATION ☐ MISUSE OF TOOLS/EQUIPMENT ☐ REMOVING SAFETY DEVICES ☐ UNAUTHORIZED OPERATION ☐ UNSAFE BODILY POSITION ☐ UNSAFE SPEED ☐ USING UNSAFE EQUIPMENT ☐ WEARING IMPROPER ATTIRE ☐ NO UNSAFE ACT ☐ OTHER _____

Email: SIPE@slosipe.org or Mail: 7455 Morro Road, Atascadero, CA 93422

PLEASE EMAIL OR MAIL A COPY OF THIS REPORT TO SIPE WITHIN 10 BUSINESS DAYS.

SUPERVISORY RESPONSIBILITY

- ☐ FAILURE TO ENFORCE SAFETY RULES
- ☐ FAILURE TO PROVIDE PROPER PPE
- ☐ FAILURE TO PROVIDE PROPER TOOLS
- ☐ LACK OF EQUIPMENT
- ☐ LACK OF OVERSIGHT/SUPERVISION
- ☐ LACK OF PLANNING
- ☐ LACK OF PROCEDURES
- ☐ POOR COMMUNICATION
- ☐ WRONG PERSONNEL ASSIGNED
- ☐ IMPROPER MAINTENANCE
- ☐ INADEQUATE INSPECTIONS
- ☐ NOT APPLICABLE
- ☐ OTHER _____

DESCRIPTION OF ACCIDENT TO BE COMPLETED **WITH** INJURED EMPLOYEE (*ATTACH A SEPARATE SHEET IF NECESSARY)*

Describe in detail what happened:

Provide exact location where accident occurred and be specific:

Describe how the injury occurred:

Describe the activity, sequence of events, and conditions that led to this accident:

Could the accident have been prevented? ☐ YES ☐ NO Please explain:

Names and statements from witnesses:
(ATTACH STATEMENT ON A SEPARATE SHEET)

Name: _____ Name: _____

CORRECTIVE ACTION

What corrective action will be taken to prevent recurrence?

Who is responsible for corrective action and what is the expected completion date?

Name: _____ Date: _____ Name: _____ Date: _____

REQUIRED SIGNATURES

INVESTIGATED BY: _____ DATE: _____

REVIEWED BY DIRECTOR/SITE ADMINISTRATOR: _____ DATE: _____

REVIEWED BY DISTRICT SAFETY COORDINATOR: _____ DATE: _____

PRINT THE NAME OF THE PERSON FILLING OUT THIS REPORT: _____ DATE: _____