



SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

EMPLOYEE NAME _____ SOCIAL SECURITY # _____
 EMPLOYEE ADDRESS _____
 TELEPHONE NU: HOME _____ WORK _____
 MARITAL STATUS _____ DATE OF HIRE _____
 DEPARTMENT _____ OCCUPATION _____
 DATE OF BIRTH _____ SEX(M or F) _____ AVERAGE WEEKLY WAGE _____
 NUMBER OF DEPENDENTS _____ DATE OF INJURY _____
 DESCRIPTION OF INJURY _____
 LOCATION ACCIDENT OCCURRED _____
 WITNESS _____ WITNESS ADDRESS _____
 TELEPHONE NU: _____
 TO WHOM WAS INJURY REPORTED TO/THEIR POSITION _____
 DID EMPLOYEE LOSE TIME FROM WORK? (Y or N) _____
 WAS MEDICAL TREATMENT SOUGHT?(Y or N) _____ Tax ID Number: _____
 MEDICAL FACILITY _____
 DATE REPORTED A WORK RELATED: _____ INJURY: _____ BODY PART: _____
 RETURN TO WORK DATE: _____

*******Supervisor's Complete Below*******

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED?WHY?

CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY

WAS EMPLOYEE WEARING SAFETY GEAR? YES _____ NO _____ (IF NO, EXPLAIN)

ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS _____

REMARKS _____

Investigated By _____ Date _____

Reviewed By _____ Date _____

School Nurse

Supervisor