

The Alliance

The Arizona School Alliance for Workers' Compensation, Inc.

Supervisor's Incident Report

Complete and submit this report to the district office within 24 hours from notice of accident.

Fatalities must be reported immediately.

EMPLOYEE INFO	Name: _____	SS#: _____	Date of Birth: _____
Home Address: _____	City: _____	State: _____	Zip: _____
District: _____	Home Phone: _____		
School/Dept: _____	Job Title: _____	Cell Phone: _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Dependents: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Hire: _____	Reg. Shift: From _____ <input type="checkbox"/> AM <input type="checkbox"/> PM To _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Pre-employment Physical Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employment: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Intermittent	Months: <input type="checkbox"/> 10 <input type="checkbox"/> 12 <input type="checkbox"/> Other	Wage: \$ _____ <input type="checkbox"/> hr <input type="checkbox"/> wk <input type="checkbox"/> mth	

ACCIDENT INFO	Date of Injury/Illness: _____	Time of Event: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Fatality: <input type="checkbox"/> YES <input type="checkbox"/> NO
Location Description (i.e. parking lot): _____	Date Supervisor Notified: _____	On Site: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Accident Address (if not on premises): _____	City: _____	State: _____	Zip: _____
Employee Description of Accident: _____			
Last Day of Work after Injury: _____ Date of Return to Work: _____ Still Off: <input type="checkbox"/> Yes <input type="checkbox"/> No Validity doubted: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of First Treatment: _____ Name of Clinic/ER/Hospital: _____ Phone: _____			
Object or substance that harmed employee (i.e. student, hammer, etc): _____ What was employee doing just before incident (be specific): _____			

ACCIDENT TYPE	PART OF BODY	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Other
<input type="checkbox"/> Strain/sprain	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Ear
<input type="checkbox"/> Slip/Trip/Fall	<input type="checkbox"/> Ankle	<input type="checkbox"/> Eye
<input type="checkbox"/> Hit by/Struck against	<input type="checkbox"/> Arm	<input type="checkbox"/> Face
<input type="checkbox"/> Laceration/puncture	<input type="checkbox"/> Back	<input type="checkbox"/> Finger
<input type="checkbox"/> Burn-heat/scald/shock	<input type="checkbox"/> Chest	<input type="checkbox"/> Foot
<input type="checkbox"/> Foreign body	<input type="checkbox"/> Other _____	<input type="checkbox"/> Groin
<input type="checkbox"/> Chemical Exposure	<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Hand
<input type="checkbox"/> Needle Stick	<input type="checkbox"/> Vehicle Accident	<input type="checkbox"/> Head
<input type="checkbox"/> Assault	<input type="checkbox"/> Other _____	<input type="checkbox"/> Knee
<input type="checkbox"/> Other _____		<input type="checkbox"/> Leg
		<input type="checkbox"/> Shoulder
		<input type="checkbox"/> Toe
		<input type="checkbox"/> Wrist
		<input type="checkbox"/> Other: _____

INVESTIGATION	<input type="checkbox"/> Preventable <input type="checkbox"/> Not preventable
Did another person not in company employ caused accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name: _____	Address: _____ Phone: _____
Witness Name: _____	Witness Address: _____ Witness Phone: _____
Witness Statement, if any: _____	

UNSAFE CONDITION	UNSAFE PERSONAL FACTORS
<input type="checkbox"/> Improperly guarded	<input type="checkbox"/> Improper attitude
<input type="checkbox"/> Safety devices inoperative	<input type="checkbox"/> Lack of required safety knowledge
<input type="checkbox"/> Effective	<input type="checkbox"/> Defective eyesight
<input type="checkbox"/> Hazardous arrangement	<input type="checkbox"/> Defective hearing
<input type="checkbox"/> Improper illumination	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Improper ventilation	<input type="checkbox"/> Muscular weakness
<input type="checkbox"/> Lack of suitable PPE	<input type="checkbox"/> Pre-existing heart weakness
<input type="checkbox"/> Unsafe dress or apparel	<input type="checkbox"/> Pre-existing hernia
<input type="checkbox"/> Hazardous dust, gases or fumes	<input type="checkbox"/> Appears intoxicated
<input type="checkbox"/> Unclassified (give details): _____	<input type="checkbox"/> Unclassified (give details) _____
<input type="checkbox"/> No unsafe condition	<input type="checkbox"/> No unsafe personal factor

UNSAFE ACT	<input type="checkbox"/> Handling materials incorrectly	<input type="checkbox"/> Distracting, teasing, or horseplay
<input type="checkbox"/> Working/operating without authority	<input type="checkbox"/> Working with overactive child	<input type="checkbox"/> Not following rules or instruction
<input type="checkbox"/> Working on moving machinery	<input type="checkbox"/> Using defective tools	<input type="checkbox"/> Unsafe decision
<input type="checkbox"/> Working on dangerous equipment	<input type="checkbox"/> Using hands instead of tools	<input type="checkbox"/> Unclassified (give details) _____
<input type="checkbox"/> Working at unsafe speeds	<input type="checkbox"/> Unsafe loading or unloading	
<input type="checkbox"/> Making safety devices inoperable	<input type="checkbox"/> Failure to use personal protective equipment	<input type="checkbox"/> No unsafe condition
<input type="checkbox"/> Taking unsafe position or posture		

REQUIRED CORRECTIONS	<input type="checkbox"/> Pre-job training	<input type="checkbox"/> Improve clean-up process	<input type="checkbox"/> Install/revise safety guards	<input type="checkbox"/> Discipline employees involved
<input type="checkbox"/> Retraining of all staff	<input type="checkbox"/> Improve enforcement	<input type="checkbox"/> Improve storage arrangement	<input type="checkbox"/> Require PPE	<input type="checkbox"/> Warn employees involved
<input type="checkbox"/> Improve illumination	<input type="checkbox"/> Eliminate congestion	<input type="checkbox"/> Revise job procedure	<input type="checkbox"/> Repair/replace equipment	<input type="checkbox"/> Reinstruct employees involved
<input type="checkbox"/> Improve ventilation			<input type="checkbox"/> Require safer materials (explain)	<input type="checkbox"/> Job reassignment
<input type="checkbox"/> Improve inspection process			<input type="checkbox"/> Improve design/construction	<input type="checkbox"/> Other _____

PERSONS RESPONSIBLE FOR CORRECTION	COMPLETE DATE	FOLLOW UP WITH EMPLOYEE	Date: _____
_____	_____	Comments: _____	
_____	_____	_____	
_____	_____	_____	

SUPERVISOR	Name: _____	Phone: _____	Email: _____
Signature: _____			Date: _____
APPROVED BY	Name: _____	Phone: _____	Email: _____
Signature: _____			Date: _____