Oregon City School District

Code: **EBBB-AR**
Revised/Reviewed: 05/2001; 11/13/17
Orig. Code(s): EBBB-AR

Supervisor's Incident Report

This report is to be completed by the injured employee at the time of the accident, signed by his/her supervisor the same day as the accident, and sent immediately to the payroll department. If the employee seeks any medical treatment, they must complete the claim form.

TO BE COMPLETED BY THE EMPLOYEE:

First Name M.I. Last Name		Home Address		
Home Phone	Work Phone	Birthdate	Sex	Social Security No.
Date and Time of Injury		Location/Building where injury occurred:		
Do you plan to seek medical treatment:		Nature of injury:		Working Shift

Describe in detail how the injury occurred. Include what you were doing, what equipment/tools were in use, what went wrong, and names of any other persons involved in this event.

I acknowledge that I have fully completed the above and authorize the release of medical information relating to this claim.

Employee Signature _____ Date _____

TO BE FILLED OUT BY SUPERVISOR: (Immediately after learning of injury/exposure)

Name(s) of Witnesses: (list address if not district employee)

_____

If accident caused by someone other than worker, list name and address:

_____

Has employee had previous injury/conditions to or near injured part of body? ☐ Yes ☐ No

_____

If operating machinery/equipment, list types here: Were safeguards provided/used?

_____

Did worker return to next shift? Date and Time Worker Left Work Date and Time Worker Returned

Date: Hour: Date: Hour:

What corrective action have you made to prevent future incidents?

_____

Do you feel that the injury was a valid on-the-job injury? ☐ Yes ☐ No
Comments:

_____

Describe in your own words what happend:

Supervisor's Signature: _____ Date: _____