School District of Manawa

"Students Choosing to Excel, Realizing their Strengths"

ACCIDENT REPORT

Work-related accidents involving injury or illness and near miss incidents require an accident report to be completed. Accident Reports shall be completed as soon after the accident as possible, but no later than the end of the workday the accident occurred.

Employee Instructions

1. Complete Sections 1 and 2.
2. Upon completion of the Sections1 and 2, sign Section 3 and forward the report to your supervisor.
3. Complete the accident investigation with the district nurse.

Supervisor Instructions

1. Review the completed Accident Report for accuracy and sign off on Section 4.
2. Employee and health office shall review the accident report together and then perform the accident investigation (Section 4, 5 and 6). The health office shall lead the investigation.
3. Upon completion of the accident investigation, district nurse and employee shall sign Section 7.
4. The completed accident report and accident investigation, shall be forwarded to the superintendent, business manager, and building supervisor.

SECTION 1: EMPLOYEE INFORMATION

Name: (first, middle, last)					
Soc. Sec. #: (optional)		**Date of Birth:**		**Sex:**	☐M ☐F
Street Address:					
City:		**State:**		**Zip:**	
Home Phone:		**Cell Phone:**			
Date of Hire:		**Job Title:**			
Employment Status:	☐ Full Time ☐ Part Time ☐ Temporary ☐ Other				
Length of Employment:	☐ < 6 mos. ☐ 6 mos. – 1 yr. ☐ 1 – 3 yrs. ☐ 3- 5 yrs. ☐ 5-10 yrs. ☐>10yrs.				

SECTION 2: ACCIDENT INFORMATION

Type of Accident:	☐ Injury/Illness ☐ Near Miss	**Date of Accident:**	
		Time of accident:	
Where did the accident happen? (Identify building, room, machine, street, etc.)			
Provide a detailed summary of the accident. (What was the employee was doing, what equipment was involved, who was in the area, what events lead up to the accident, etc.)			

Injury Type		**Affected Body Part**		
☐ Laceration	☐ Repetitive Motion	☐ Eye	☐ Hand	☐ Toes
☐ Bruise	☐ Respiratory	☐ Head	☐ Fingers	☐ Internal Organs
☐ Crush	☐ Chemical Exposure	☐ Neck	☐ Hip	☐ Lungs
☐ Puncture	☐ Amputation	☐ Back	☐ Upper Leg	☐ Other
☐ Foreign Body	☐ Loss of eye	☐ Shoulder	☐ Knee	
☐ Burn	☐ Other:	☐ Arm	☐ Lower Leg	
☐ Fracture		☐ Elbow	☐ Ankle	
☐ Sprain / Strain		☐ Wrist	☐ Foot	

☐ YES ☐ NO	**Did the accident get reported to MEDCOR?**	Date:	
		Time:	
		Confirmation #:	
☐ YES ☐ NO	**Did the employee seek medical attention?**	Clinic or Hospital:	
		Physicians Name	
		Street Address:	
		City. State & Zip:	
		Phone #:	
☐ YES ☐ NO	**Bloodborne Exposure:** Did any individuals have a significant exposure to blood or other potentially infectious materials due to the incident? (If "YES", immediately report the exposure to health office)		

Comments / Notes:

SECTION 3: ACCIDENT REPORT SIGNATURES

The information provided in this accident report provides a true, accurate and complete account of the accident.

Employee:_____ Date:_____

District Nurse:_____ Date:_____

Administrator:_____ Date:_____