

Butler County Educational Service Center Employee Incident/Accident Report

Employee to complete this section (within 48 hours) **Date of report** _____

1. Workplace Location _____ District _____

Involved Employee's Name _____

Employee's Home Address _____

Employee's Home Phone _____ Work Phone _____

Employee's Date of Birth _____ Employee's Gender: Female Male

Employee's Social Security Number ____-____-____ Job Title _____

Incident/Accident Information

Employee to complete this section

2. Date of accident _____ Time of Accident _____ A.M./P.M.

Was supervisor notified of accident? _____ When? _____ By? _____

Supervisor's Signature _____

3. Did anyone witness your incident/accident? No Yes If yes, supply the following information:

Witness' Name _____ Title _____

Witness' Home Address _____

Witness' Home Phone _____ Witness' Work Phone _____

If there are additional witnesses, attach another sheet of paper with information regarding those witnesses.

4. Describe the incident/accident in your own words. Please give all details so that this accident may be used to prevent injury to others. Please print legibly. _____

5. Please describe each injury, if any, that resulted from this incident/accident. Be sure that you state the body part(s) affected, the nature of the injury (cut, bruise, burn, etc.). _____

6. Specifically (hallway, meeting room, classroom number, etc.) where did this incident/accident occur?

7. Were there contributing causes (ice on pavement, water on floor, broken equipment, lack of training, fatigue, etc.)? State specifically what those were. _____

8. Were you using any safety precautions at the time of the incident/accident? Please describe: _____

9. Was there any damage to property, equipment, or supplies? Please describe: _____

It is important for you to report to the nurse in your building, or the building where the incident/accident took place, at the earliest opportunity, so that your injuries may be assessed. You must do this whether or not you feel you have sustained an injury. Please take this form with you so that the nurse may complete it.

Employee signature _____ (Employee's supervisor may complete and sign if employee is unable.)

This section is to be completed by facility nurse.

Workers Comp MCO notified? Yes _____ No _____

Date of assessment _____ Time of assessment _____

Nursing assessment: _____

Type of follow-up instructions given: _____

Date of tetanus toxoid _____ if not within 5 years (in the case of open wound), or 10 years (for closed injury or no apparent injury), was employee referred to physician for immunization? _____

Name of physician _____

Was employee sent directly home following your assessment? _____ Was employee accompanied? _____ By whom? _____

Was employee sent directly to a physician or health care facility following your assessment, or at the time of injury? _____ Name of physician or health care facility _____

Method of transportation _____

Nurse's signature _____ Date _____

Return completed form to Butler County Educational Service Center, to the attention of the Assistant Superintendent for Human Resources, Lori Thesken.