

Estacada School District
EMPLOYEE ACCIDENT INVESTIGATION

(To be completed by a supervisor within 24 hours and sent to HR and Safety Dir)

<input type="checkbox"/> Employee
<input type="checkbox"/> Volunteer

Employee Information

Name: _____

Community: _____ Job Title: _____

Department: _____ Birth Date: _____

Previous history of similar injury? Yes No Hire Date: _____

Incident Details

Date & Time of accident: _____

Where did accident take place? (be specific): _____

Body parts affected (if applicable): _____

Nature of injury (sprain, break, burn, etc.): _____

Severity (pick **one**): No Injury First Aid Medical Only Restrictions Time Off

To whom was accident reported? _____ When? _____

Names of witnesses (if any): _____

Describe accident (Who? What? Where? When?): _____

Was a known safety procedure or guideline violated? _____

Was an unsafe condition present? _____

Was safety equipment needed? (If yes, was it available and used?) _____

Could this be a third party's fault? _____

Is there a need for additional training? _____

Is disciplinary action called for, either for the injured worker or for someone who contributed to an unsafe condition? _____

_____	_____	_____
Administrators Name (print)	Administrators Signature	Date
_____	_____	_____
Injured Employees Name (print)	Injured Employees Signature	Date