GRANTS PASS SCHOOL DISTRICT NO.7
REPORT OF INCIDENT/ACCIDENT
EMPLOYEE

This form should be completed by the Employee and immediate Supervisor and returned to the Safety Officer at the District office within 24 hours.

PLEASE PRINT CLEARLY

1. Employee: _____

2. Location Employed: _____

Job Title: _____

3. Date of Accident: _____ Time: _____ AM/PM

4. Accident Location: _____

5. Describe accident fully: (What happened and why; identify unsafe conditions and/or practices).

_____

_____

6. What corrective action was taken, or is planned, to prevent similar accidents from occurring in the future?

_____

_____

7. List witnesses & phone numbers:

Name _____ Phone _____

Name _____ Phone _____

8. When was the accident reported? _____

To Whom? _____

Reported within 24 hours of the accident? Yes ( ) No ( ) If no, why?

_____

_____

9. Was the accident caused by faulty equipment? Yes ( ) No ( ). If yes - preserve evidence.
Explain:

_____

_____

10. Was the accident caused by another person not employed by your firm? Yes ( ) No ( )

Name: _____ Phone: _____ Address: _____

11. Describe injury (part of body/type of injury):

12. Describe first aid/medical treatment (when and by whom):

Did Employee go to Emergency Room or Personal Physician? Yes ( ) No ( )

13. Is a previous injury or condition of the employee a contributing factor? Yes ( ) No ( ) If yes explain:

14. Is there a reason to question whether this a job related injury or illness? Yes ( ) No ( ) If yes explain:

Employee's signature: _____ Date: _____

Supervisor's signature: _____ Date: _____

Administrator's
Signature: _____ Date: _____

Date received in District Office: _____

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