ACCIDENT INVESTIGATION REPORT

*This report must be completed by the **employee** as soon as possible after the injury. Read questions carefully and make your answers complete and accurate. This form **must be sent** to the Work Comp Department at the OSC **within 48 hours** after the accident.*

EMPLOYEE'S PERSONAL INFORMATION					
EMPLOYEE'S FULL NAME:		AGE:		GENDER:	F ☐ M ☐
HOME ADDRESS:					
CITY, STATE, ZIP CODE:					
PERSONAL EMAIL ADDRESS					
TELEPHONE #:		SOC. SEC. #:		DATE OF BIRTH:	
OCCUPATION:		DATE HIRED:		BUILDING :	
SUPERVISOR:				(where injury occurred)	

INCIDENT INFORMATION							
DATE OF INJURY:		TIME OF INJURY:		DATE REPORTED:		TIME REPORTED:	
LOCATION IN THE BUILDING WHERE ACCIDENT OCCURRED (E.G. GYM, HALLWAY, OUTSIDE, ETC.):							
DESCRIBE HOW ACCIDENT HAPPENED:							
DESCRIBE EXTENT OF INJURY; INDICATE BODY PART(S) INVOLVED:							***(CONTINUE ON BACK IF NEEDED)***
NAME SUBSTANCE OR OBJECT THAT DIRECTLY CAUSED THE INJURY:							
WAS WEATHER A FACTOR IN THIS ACCIDENT?	YES ☐ NO☐						
WERE THERE ANY WITNESSES?	YES ☐ NO☐	IF YES, MUST COMPLETE 'REPORT BY EYEWITNESS' FORM					
WERE YOU WORKING AT YOUR REGULAR JOB AT THE TIME OF THE INJURY?	YES ☐ NO☐	IF NO, EXPLAIN WHY:					
DID EMPLOYEE RECEIVE MEDICAL CARE?	YES ☐ NO☐						
IF A SLIP/TRIP/FALL INJURY, WHAT TYPE OF FOOTWEAR WAS EMPLOYEE WEARING?							
IF A STUDENT INITIATED INJURY, HAS THERE BEEN ACTION TAKEN BY SUPERVISOR TO PREVENT A REOCCURRENCE?	YES ☐ NO ☐	STUDENT ID#					
IF YES, DESCRIBE ACTION TAKEN:							
WAS EMPLOYEE WEARING/USING REQUIRED SAFETY EQUIPMENT?	YES ☐ NO☐						
HOW COULD THIS ACCIDENT HAVE BEEN PREVENTED?							
WHAT IMMEDIATE ACTION HAS BEEN TAKEN TO PREVENT THE OCCURRENCE OF A SIMILAR ACCIDENT?							
ADDITIONAL COMMENTS:							

Office Use Only

Code: ______________

DOH: ______________

Est. Wkly: ______________

SUPERVISOR: ______________

DATE: ______________

EMPLOYEE'S SIGNATURE: ______________

DATE:

April 2019

EYEWITNESS STATEMENT

*This report must be completed by the **eyewitness**. Read questions carefully and make your answers complete and accurate.*

EYEWITNESS' PERSONAL INFORMATION			
EYEWITNESS' FULL NAME:		GENDER:	F ☐ M ☐
HOME ADDRESS:			
CITY, STATE, ZIP CODE:			
TELEPHONE #:			

INCIDENT INFORMATION			
NAME OF PERSON INJURED:			
DATE OF INCIDENT:		TIME OF INJURY:	
IN YOUR OWN WORDS, DESCRIBE WHAT HAPPENED:			
DID ANYONE ELSE SEE THE ACCIDENT?		YES ☐ NO☐	
IF YES, PLEASE LIST THEIR NAMES:			
OTHER COMMENTS:			
ARE YOU AN EMPLOYEE OF OLATHE PUBLIC SCHOOLS?		YES ☐ NO☐	
IF YES, WHAT IS YOUR HOME BUILDING?		OCCUPATION	

SIGNATURE:	
DATE:	