Louisville City Schools

Accident and/or Injury Investigation – Adults Only – Principal/Supervisor Report

Name: ____________________ Date of Accident: ___/___/___ Date Reported: ___/___/___

Address: _______________________________

____

School/Building: ________________________________ Position: _______________________

What was employee doing when injury occurred? _____________________________________

____

(Be specific: name, equipment used, etc.)

How did accident occur? ____

____

(Describe events leading to injury or occupational illness. Name any objects involved.)

Where and when (time) did accident occur? ____

Describe injury or illness: ____

____

Name & address of physician (If medical treatment sought):____________________________

____

Name & address of hospital (if medical treatment sought):_____________________________

____

Witnesses: _________________________________ _______________________________

Was an unsafe act the cause? Yes _____ No ______

If yes, explain: ____

Could anything be done to prohibit recurrence? _____________________________________

____

Note: Please attach a note from employee in his/her own handwriting explaining the details of the accident and/or injury that has taken place.

Please complete page 1 of this form and forward to the Treasurer's Office. Thank you.

______________________________________ ___________________

Principal/Supervisor Signature Date

Revised August 24, 2010

THIS SIDE TO BE COMPLETED BY ADMINISTRATOR FOR FOLLOW- UP ONLY

1. Was Workers' Compensation filed for this injury/illness? Yes No
2. Number of days missed due to this injury/illness; ________________ full or part days

____

____

(If part, please designate date(s) and how much of each day was missed)

3. Expected date of return: ____________________
4. What was the employee's actual return to work date? ________________
5. Did employee have any restrictions upon returning to work, if so, please explain: Yes No

____

____

6. Was surgery necessary for this illness/injury? Yes No

   If yes, surgery date: ____________________________

7. Was employee on the clock when injury/illness occurred? Yes No
8. Any other notes/important information concerning this injury/illness we should be aware of:

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Completed by: ________________________________ Date: ____________________________

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THIS SECTION TO BE COMPLETED BY TREASURER'S OFFICE

Received in Treasurer's Office: Date: ________________

1. Workers' Compensation Claim Number: __________________________
2. Talked with Workers' Compensation: ______________________ Date: _________________
3. Workers' Compensation Report Complete _______________________